Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act

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Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act

Michael Lee, Jr.*

INTRODUCTION ........................................................ 560

I. FOUR COMPONENTS .......................................................... 562
   A. Prohibiting Health Status Discrimination .......................... 562
   B. The Mandate ................................................................ 565
   C. Subsidies ................................................................... 567
   D. Cost-Reducing and Revenue-Generating Provisions ............. 569
   E. Other Provisions .......................................................... 573

II. THE ARCHITECTURE OF REFORM ......................................... 575
    A. Solidarity Insurance and Community Rating ....................... 576
    B. Adverse Selection and the Mandate .................................. 577
    C. Expenses and Subsidies ............................................... 579
    D. Deficits, Taxes, and Spending Cuts .................................. 581
    E. The Philosophical Core and Political Robustness ............... 585

III. PAVED WITH GOOD INTENTIONS ........................................ 585
    A. Solidarity and Insurance Gamesmanship ............................ 586
    B. The Mandate: Fines, Premiums, and Civic Duty ................ 588
    C. Expanded Access but Provider Exodus ............................. 593
    D. Deficits: A Wink, a Nod, and the Sustainable Growth Rate .... 597

CONCLUSION ......................................................................... 601

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INTRODUCTION

On March 24th, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA), declaring “everybody should have some basic security when it comes to their health care.” Lauded by the media as “the most expansive social legislation enacted in decades,” PPACA, and its companion bill, the Health Care and Education Reconciliation Act of 2010 (HCERA), known jointly as the Affordable Care Act (ACA), are tremendously complex pieces of legislation. Congress aimed, among other goals, to expand coverage and reduce costs. Additionally, the President discussed the need for security and stability in the face of objectionable insurance industry practices:

One man from Illinois lost his coverage in the middle of chemotherapy because his insurer found that he hadn’t reported gallstones that he didn’t even know about. They delayed his treatment, and he died because of it. Another woman from Texas was about to get a double mastectomy when her insurance company canceled her policy because she forgot to declare a case of acne. By the time she had her insurance reinstated, her breast cancer had more than doubled in size. That is heart-breaking, it is wrong, and no one should be treated that way in the United States of America.

3. Id.
7. President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), available at http://www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care (arguing that health care had become unaffordable and that too many Americans were uninsured).
8. Id.
The above examples illustrate the President’s main argument: that the insurance industry currently discriminates against the sick and the unhealthy, using even trivial matters to deny coverage. This is not a new complaint. The President has described the need to regulate insurance companies, who “treat their customers badly—by cherry-picking the healthiest individuals and trying to drop the sickest, by overcharging small businesses who have no leverage, and by jacking up rates.” The President further argued that the reform proposal—the proposal that would eventually evolve into the ACA—could solve these problems by providing security and stability to current policyholders, expanding coverage, and slowing the growth rate of health costs. For its part, the Congressional Budget Office (CBO) estimated that the ACA would reduce federal deficits by $143 billion between 2010 and 2019 while reducing the ranks of the nonelderly uninsured by 32 million, from about 17% to about 6%.

This Note aims to evaluate the ACA as a means of providing security and stability in insurance, increasing access to health insurance, and reducing medical expenditures. Any in-depth evaluation of the ACA’s goals, however, must assess the legislation’s provisions and Congress’s probable intentions and priorities alongside a policy and economic analysis. Accordingly, this Note proceeds in three Parts. Part I provides a broad review of these highly complex statutes at their full implementation. It focuses on those changes, especially the ban on health status discrimination, that will most dramatically affect insurance coverage, the centerpiece of the legislation. Part II argues that the central provision of the ACA is the ban on health status discrimination. In order to make

9. Id.
11. See Obama, supra note 7.
12. Id.
14. Id. at 9.
15. There are several temporary provisions within the ACA. See, e.g., PPACA, Pub. L. No. 111-48, § 1101, 124 Stat. 119, 141 (2010) (requiring HHS to establish a temporary high-risk pool which will continue through 2013 and end promptly thereafter).
16. PPACA also creates changes in the health care workforce, preventive care services, and many other areas that chiefly impact providers and should have little direct effect on patients. See, e.g., id. §§ 4001-402, 124 Stat. at 538-88; id. §§ 5001-701, 124 Stat. at 588-684.
that ban possible, a mandate that all citizens purchase insurance was necessary to prevent people from waiting until after they became sick to purchase insurance. In order to make a mandate possible, the ACA then had to provide subsidies for insurance purchases. And in order to finance the subsidies, the legislation had to impose a variety of tax increases and spending cuts. In other words, once the ACA prohibited insurers from discriminating against those with preexisting conditions, the mandate, subsidies, and revenue provisions became absolutely necessary.

Finally, Part III assembles the evidence available to argue that the ACA, despite its admirable intentions, is unlikely to accomplish its goals. Economic projections, including projections from CBO itself, demonstrate that market forces will probably undermine Congress’s intentions. The ACA will not eliminate insurer discrimination; may exacerbate rather than alleviate medical deprivation; and will almost certainly not result in reduced federal deficits. Most importantly, the ACA’s methods for preventing the unraveling of health insurance are most likely inadequate because the costs of health insurance are likely to rise dramatically. The ACA, if it proceeds as expected, will almost certainly be a self-defeating piece of legislation.

I. Four Components

The ACA’s most important implications concern access to and the cost of health insurance. To that end, the legislation has four major components: prohibiting discrimination against preexisting conditions, mandating the purchase of insurance, providing subsidies for premium assistance, and raising revenue and reducing government expenditures. Part I examines each of these in turn, beginning with the central provision of the ACA: the prohibition on discrimination against preexisting conditions.

A. Prohibiting Health Status Discrimination

The ACA asserts several major protections for the unhealthy in the insurance market. First, the ACA requires insurers to provide insurance policies to all applicants, a requirement known as “guaranteed issue.” All applicants, even those with preexisting illnesses, must be accepted. The ACA additionally prohibits insurers from canceling policies based on innocent misrepresentations in original insurance applications, a practice known as rescission. The legislation further requires that insurers continue coverage and guarantee

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17. Id. § 1201, 124 Stat. at 156 (“Each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.”).
18. Id. § 1501, 124 Stat. at 243.
19. Id. § 1001, 124 Stat. at 131.
ADVERSE REACTIONS

renewability.20 Congress specifically prohibits discrimination based on “health status-related factors,” including health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability; in the event that Congress overlooked any possible form of discrimination against the unhealthy, the ACA grants the Secretary for Health and Human Services (HHS) authority to prohibit discrimination on the basis of any other health status-related factor.21

These regulations, of course, are useless without accompanying rate regulation. Without rate regulation, insurers could simply charge risk-related premiums, which many chronically ill individuals probably could not afford. The plan thus prohibits rate discrimination based on health status.22 It permits premiums to vary only by: (1) whether the plan is meant for individuals or families, (2) geography, (3) age, and (4) tobacco use.23 Congress emphasizes that a “rate shall not vary with respect to the particular plan or coverage involved by any other factor not described” above.24 In particular, the law emphasizes that there is to be no discrimination based on salary.25

These regulations will seriously restrict insurers from charging different premiums to different patients. Rate variation by geography will be permitted only within defined geographic units. These units will be determined by states and are subject to veto by HHS.26 It will be legal to charge different rates, for example, to Texans compared to Californians, but the state of California could prohibit charging different premiums to residents of downtown Oakland as compared to residents of Beverly Hills. Additionally, insurers may adjust premiums based on age, but only up to a maximum differential of 3:1—that is, they may only charge the elderly three times what they charge the young.27 Currently, average premiums are 4.26 times higher for a sixty-four year old than for an eighteen year old,28 and so the ACA appears to mandate at least a 42% increase in relative premiums for young policyholders. The relative increase may be even larger if the elderly—those over age 64—are included in the final

20. Id. § 1201, 124 Stat. at 156.
21. Id.
22. Id.
24. Id.
25. Id. § 1001, 124 Stat. at 135.
26. Id. § 1201, 124 Stat. at 155.
27. Id.
Specific “permissible age bands,” yet to be determined by HHS, will establish whether rates may vary only in “bands” such that, for example, everybody between the ages of 25 and 30 (or 25 and 35, or 25 and 45) must be charged the same premium. Finally, insurers will be permitted to charge higher premiums to smokers, with a maximum differential of 1.5 to 1. The statute prohibits differential premiums based on other unhealthy behaviors such as other substance abuse, risky sexual practices, unhealthy eating or exercise habits, or medication compliance.

The legislation also includes a variety of other insurance requirements. To highlight just a few, insurance plans must: have no annual or lifetime coverage limits; cover preventive care; cover dependents until age twenty-six; and cap out-of-pocket spending at $2,250 (adjusted for inflation). Insurers must spend at least 80% of revenue from premiums on incurred claims losses, and all plans must meet certain minimum standards to be determined by HHS.

The core element of the legislation, however, remains the ban on health status discrimination. In short, Congress has dramatically curtailed insurers’

29. PPACA § 1201, 124 Stat. at 155. As of July 2010, the Federal Register implied that permissible age bands had not yet been determined. See HHS Pre-Existing Condition Insurance Plan Program; Interim, 75 Fed. Reg. 45,108 (proposed July 30, 2010) (to be codified at 45 C.F.R. pt. 152) (“[T]he Affordable Care Act requires HHS, in consultation with NAIC, to define permissible age bands for rating purposes in the individual and group markets. However, the rating bands established under section 2701 will not be effective until January 1, 2014 . . . .”).
32. PPACA § 1001, 124 Stat. at 131, amended by § 10101(a).
33. Id., 124 Stat. at 131.
34. Id., 124 Stat. at 132.
36. PPACA § 10101(f), 124 Stat. at 886. The required “medical loss ratio” is 85% in the large group market. Id.
37. Additional requirements for a minimum plan appear in PPACA § 1302(b)(1), 124 Stat. at 163-64; see infra text accompanying notes 46-48 (describing qualifying minimum plans); infra text accompanying note 46 (describing the requirement that all plans be “comprehensive”).
ADVERSE REACTIONS

ability to screen their patients—to “cherry-pick.” This is, of course, precisely the goal of the ACA. And yet, protection of the unhealthy begs an obvious question: What is to stop a person from purchasing insurance only after becoming ill? Such behavior, if widespread, would bankrupt the insurance industry.

B. The Mandate

The second major prong of the ACA is the mandate, which requires all individuals to either purchase an insurance policy or pay a fine in the form of a new tax. The tax scales up over time, reaching its peak in 2015 and thereafter. After 2015, it will amount to the greater of $695 or 2.5% of the taxpayer’s income in excess of the threshold amount at which a tax return is required. The fine would be paid as part of a tax return, and is codified in the Internal Revenue Code, and will depend on the Internal Revenue Service (IRS) for implementation and enforcement.

The mandate will require any individual who is not “covered under minimum essential coverage” for any single month to pay the fine. “Minimum

38. See Obama, supra note 7.
39. Id.
41. Among other provisions, the individual mandate has been challenged on constitutional grounds. See, e.g., Fla. ex rel. McCollum v. U.S. Dept. of Health & Human Servs., 716 F. Supp. 2d 1120 (N.D. Fla. 2010); Virginia ex rel. Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010). The constitutional merits of these lawsuits are beyond the scope of this Note, but Congress issued the relevant findings arguing for constitutionality precisely into this section of PPACA, perhaps anticipating challenges. See PPACA § 1501(a), 124 Stat. at 242-44.
42. PPACA § 1501, 124 Stat. at 242-245, amended by § 10106, 124 Stat. at 907; amended by HCERA § 1002, 124 Stat. at 1032. This is generally greater than the fine in the original Senate bill, which would have been $750. Id. § 1501, 124 Stat. at 242-245 (listing $750 as the fine before being subsequently amended). The threshold amount for a tax filing seems to be $9350 for a single filer or $18,700 for a joint filing. See I.R.C. §§ 6012(a)(1), 151(d)(1) (indicating that no return needs to be filed for incomes below the exemption amount, and that that exemption amount is $2,000 adjusted for inflation since 1989); INTERNAL REVENUE SERV., 1040 INSTRUCTIONS 8 CHART A (2010), available at http://www.irs.gov/pub/irs-pdf/1040.pdf (listing updated threshold amounts). The ACA’s actual fine would thus be $2,500, for example, for an individual making $109,350 a year, or for a family making $18,700 a year.
43. PPACA § 1501(b), 124 Stat. at 244.
44. Id.
45. Id. § 1501, 124 Stat. at 242 (“Requirement to Maintain Minimum Essential Coverage”); id. § 1501(b), 124 Stat. at 244 (describing penalties).
essential coverage," however, is not defined in the ACA itself. Although the ACA indicates that any minimum plan must include ambulatory services, emergency services, hospitalization, maternity care, mental health and substance abuse services, prescription drugs, rehabilitation, laboratory testing, preventive care, and pediatric services, the statute does not define the full range of services that constitute minimum essential care. HHS is assigned the task of completing this definition and has considerable discretion.

Importantly, the fine under the mandate also contains a hardship exemption: No fine shall be imposed if the cheapest plan that would satisfy the mandate would charge premiums greater than 8% of an individual’s income. Depending on what the eventual price of health insurance will be—which in turn depends upon exactly what the mandate includes—this hardship exemption might apply to a large number of families. HHS has the authority to revise that 8% threshold in accordance with the excess of the rate of premium growth compared to the rate of income growth.

In addition to the individual mandate, Congress also imposed penalties to encourage employers to provide their employees with health insurance. First, employers with more than fifty employees must either offer coverage to each employee or pay a fee of $2,000 per year for each employee beyond the first thirty. That is, a firm employing 130 employees must pay $200,000 (if any one

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46. *See, e.g., id. § 1302(b)(1), 124 Stat. at 163-64. All plans, for example, must cover maternity care, with no exception for male policyholders. Id.; see also id. § 1201, 124 Stat. at 161 (requiring all health insurers provide comprehensive coverage, which effectively outlaws new issuance of “catastrophic” plans except in specific situations); id. § 10902, 124 Stat. at 1016 (limiting payments to health flexible spending arrangements). The ACA does permit what it refers to as a “catastrophic” plan, which treats the out-of-pocket cap as a deductible. This plan also requires three primary care visits to be included and restricts eligibility for the individual market to those who are under 30 or for whom the hardship exemption applies. See id. § 1302(e), 124 Stat. at 168; infra text accompanying note 49.*

47. *Id. § 1302(b), 124 Stat. at 163 (“[T]he Secretary shall define the essential health benefits . . . .”).*

48. *Id. § 1003, 124 Stat. at 139.*

49. *Id. § 1501(b), 124 Stat. at 246. The ACA also contains a religious exemption. Id. (referencing § 1311(d)(4)(H), 124 Stat. at 177).*

50. *See infra Section III.B.*

51. *If insurance were to cost, for example, $12,000 a year, then any family making less than $150,000 a year would be exempt from the fine. See infra note 219 and accompanying text.*

52. *PPACA § 1501(b), 124 Stat. at 247.*

53. *Id. § 1513(a), 124 Stat. at 253, amended by HCERA, Pub. L. 111-152, § 1003(b)(2), 124 Stat. 1029, 1033 (2010).*
of these employees receives a subsidy). If those employers do provide health insurance to only some employees, the fee rises to $3,000 per employee beyond the first thirty if any employee receives a subsidy. This higher fee is presumably designed to penalize employers who provide coverage for some, but not all, employees. The ACA also requires that employers provide health insurance vouchers to certain employees, and the legislation provides substantial tax incentives for small businesses. At its core, however, the mandate is simple: Individuals, whether healthy or sick, are required to have health insurance. If their employers do not provide insurance, then employees must purchase it themselves.

C. Subsidies

The ACA also provides two kinds of subsidies: one to assist in the payment of insurance premiums, and one to assist in the costs that patients must pay as part of their care even when they are insured. First, federal tax credits provide premium assistance for families who fall beneath certain income thresholds and do not have employer-provided insurance. The ACA provides a scaled subsidy structured to ensure that no family pays more than a certain percentage of its income towards health insurance premiums. These percentages are based on the Federal Poverty Line (FPL) ($22,050 for a family of four in 2010), such

54. See infra Section I.C. for a discussion of subsidies under the ACA. Presumably, any business where no employee has a low enough income to qualify for the subsidy would not pay any fines. See PPACA § 1513(a), 124 Stat. at 253, amended by HCERA § 1003(b)(2), 124 Stat. at 1033.
55. Id. § 1513(b), 124 Stat. at 253-54, amended by HCERA § 1003(b)(1), 124 Stat. at 1033.
56. Specifically, employers who offer coverage are also required to offer vouchers equivalent to their usual contribution to any employee for whom the required employee contribution would be between 8.0% and 9.8% of income. Id. § 10108(c)(1)(a), 124 Stat. at 912. These vouchers will be usable in an Exchange. Id. For discussion of the Exchanges, see infra Section I.E (citing, inter alia, § 1311, 124 Stat. at 173).
57. PPACA § 1421, 124 Stat. at 237, amended by § 10105(e), 124 Stat. at 906.
58. Id. § 1401, 124 Stat. at 213-14.
that taxpayers would pay no more than the following for the applicable second-lowest-cost “silver” plan:61

Table 1: Premium Subsidy62

<table>
<thead>
<tr>
<th>Income (% of the FPL)</th>
<th>Maximum Premium Contribution (% of income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133</td>
<td>2.0</td>
</tr>
<tr>
<td>133-150</td>
<td>3.0-4.0</td>
</tr>
<tr>
<td>150-200</td>
<td>4.0-6.3</td>
</tr>
<tr>
<td>200-250</td>
<td>6.3-8.05</td>
</tr>
<tr>
<td>250-300</td>
<td>8.05-9.5</td>
</tr>
<tr>
<td>300-400</td>
<td>9.5</td>
</tr>
</tbody>
</table>

In other words, the subsidy is not a flat amount: It is an effective cap on how much a family must pay for health insurance premiums. The subsidy functions on a linear sliding scale,63 except that it appears to cut off suddenly after 400% of the FPL.64 For the 2010 FPL, subsidies would thus be provided for individuals with incomes below $43,320, and families with incomes below $88,200. The subsidy will be adjusted based on premium growth over and above general income growth.65

The ACA also provides subsidies meant to reduce “cost-sharing” provisions such as deductibles and co-pays. The government will refund credits equivalent to the following amounts of incurred cost-sharing:

61. The “Silver” plan is a plan included at the second tier in State exchanges. See infra Section I.E.
63. Id.
64. Id. Congress may have believed that the price of health insurance would be less than these caps anyway—that is, less than 9.5% of $88,200—which would alleviate the suddenness of the transition.
65. Id. § 1001(a)(1)(B), 124 Stat. at 1031.
ADVERSE REACTIONS

Table 2: Cost-Sharing Subsidy

<table>
<thead>
<tr>
<th>Income (% of the FPL)</th>
<th>Cost-Sharing Reduction (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150&lt;sup&gt;66&lt;/sup&gt;</td>
<td>94</td>
</tr>
<tr>
<td>150-200</td>
<td>87</td>
</tr>
<tr>
<td>200-250</td>
<td>73</td>
</tr>
<tr>
<td>250-400</td>
<td>70</td>
</tr>
</tbody>
</table>


The ACA also contains several provisions designed to generate revenue for, and to reduce medical spending by, the federal government. Roughly, these provisions fall into three categories: (1) tax increases and new taxes; (2) direct spending reductions; and (3) pro-competitive arrangements.

First, the ACA contains several tax increases. Most obviously, the fines from the individual<sup>68</sup> and employer mandates<sup>69</sup> will generate some revenue. The legislation also imposes a 40% excise tax, popularly referred to as the “Cadillac tax,”<sup>70</sup> on the value of any employer-sponsored insurance plan that exceeds annual values of $10,200 for an individual or $27,500 for a family, as adjusted for 2018,<sup>71</sup> based on the increase in the costs of health insurance for the Federal Employees Health Benefits Plan (commonly known as FEHBP).<sup>72</sup> The ACA also imposes 0.9% in additional income taxes on individual filers who make over $200,000 ($250,000 for a married couple).<sup>73</sup> These individuals will also pay a

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<sup>66</sup> Id. § 1001(b), 124 Stat. at 1031-32 (amending PPACA, Pub. L. No. 111-148, § 1402(c), 124 Stat. 119, 221-22 (2010)).

<sup>67</sup> Those beneath 100% of the FPL are Medicaid-eligible. See infra text accompanying note 130.


<sup>69</sup> Id. § 1513(a), 124 Stat. at 253, amended by HCERA § 1003(b)(2), 124 Stat. at 1033; id. § 1515(c), 124 Stat. at 253-54, amended by HCERA § 1003(b)(1), 124 Stat at 1033.

<sup>70</sup> For use of the term, see Editorial, Slowing Down a Cadillac: President Obama Should Defend a Vital Facet of Health-Care Reform, WASH. POS.T, Jan. 12, 2010, at A16.

<sup>71</sup> PPACA § 9001, 124 Stat. at 847, amended by HCERA § 1401, 124 Stat. at 1059.

<sup>72</sup> HCERA § 1401(a)(2)(C), 124 Stat. at 1059. Thereafter, adjustments will be based on general consumer inflation plus 1%. PPACA § 9001, 124 Stat. at 847, amended by HCERA § 1401(a)(2)(E), 124 Stat. at 1060.

new 3.8% surtax on net investment income or adjusted gross income over the threshold, whichever is less.\textsuperscript{74} The ACA also imposes a variety of new industry taxes: $27 billion over ten years in pharmaceutical industry fees,\textsuperscript{75} 2.3% excise taxes on medical devices,\textsuperscript{76} 10% service taxes on indoor tanning,\textsuperscript{77} $2-per-enrollee fees for insurers,\textsuperscript{78} and $60.1 billion over ten years in insurance industry fees.\textsuperscript{79} Finally, the ACA increases the rebates associated with the Medicaid Rebate Program,\textsuperscript{80} a program in which pharmaceutical manufacturers must “rebate” certain percentages of their sales in exchange for their products being eligible for Medicaid coverage.\textsuperscript{81}

Second, the ACA directly reduces certain federal government expenditures. In particular, it reduces a variety of types of Medicare payments to physicians and hospitals. It reduces funding for the Disproportionate Share Hospital program,\textsuperscript{82} which compensates any hospital that has a “disproportionate share” of non-paying patients.\textsuperscript{83} It completely eliminates the “Medicare Improvement Fund,”\textsuperscript{84} a fund through which HHS could have made unspecified improvements to Medicare in the years 2014 and 2015.\textsuperscript{85} It reduces payments to Medicare Advantage,\textsuperscript{86} a subset of Medicare in which plans can be administered by

\textsuperscript{74} HCERA § 1402(a), 124 Stat. at 1061.
\textsuperscript{75} PPACA § 9009, 124 Stat. at 859, \textit{amended by} HCERA § 1404, 124 Stat. at 1064.
\textsuperscript{76} HCERA § 1405, 124 Stat. at 1064. The Senate Bill’s original tax was repealed and replaced entirely by HCERA. \textit{See} PPACA § 9009, 124 Stat. at 862, \textit{amended by} § 10904, 124 Stat. 1016, \textit{repealed by} HCERA § 1405(d), 124 Stat. at 1065.
\textsuperscript{77} PPACA § 10907, 124 Stat. at 1020 (nullifying § 9017, 124 Stat. at 872, a tax on cosmetic medical procedures).
\textsuperscript{78} \textit{Id.} § 6301(e)(2)(A), 124 Stat. at 743.
\textsuperscript{80} \textit{See} PPACA §§ 2501-2502, 124 Stat. at 306-10.
\textsuperscript{82} PPACA § 2551, 124 Stat. at 312.
\textsuperscript{84} PPACA § 3112, 124 Stat. at 421.
\textsuperscript{85} 42 U.S.C. § 1395iii (Supp. II 2009).
\textsuperscript{86} \textit{See}, e.g., PPACA § 3201(b), 124 Stat. at 444 (specifying a spending freeze for a year after 2011); § 3201(d)(2), 124 Stat. at 445 (codifying a more competitive, actuarially based bidding process).
ADVERSE REACTIONS

private insurers.\textsuperscript{87} Finally, and most dramatically, the ACA implements “market basket reductions”—that is, it reduces the scheduled prices for Medicare payments to hospitals and other care providers over the next several years.\textsuperscript{88}

The legislation’s third means of reducing costs is to establish a variety of measures designed to reduce federal government medical expenses over the long term. These measures can be organized into the following categories: anti-corruption measures meant to reduce waste and fraud, pay-for-performance and pilot programs, and an independent advisory board.

The ACA contains four anti-corruption provisions. It expands the definition of “[f]ederal health care offense” and increases the sentences associated with such offenses.\textsuperscript{89} The ACA also limits new instances of physician hospital ownership,\textsuperscript{90} which is intended to reduce the incentive for physicians to order excessive services at hospitals that they own. Physicians had previously been allowed to purchase ownership shares in hospitals provided that they did not own merely one or two divisions;\textsuperscript{91} the ACA limits this “whole-hospital exception.”\textsuperscript{92} The ACA mandates disclosure of physician payments from or ownership in drug and device manufacturers.\textsuperscript{93} Finally, the ACA increases funding for the Health Care Fraud Abuse and Control Fund.\textsuperscript{94}

The second type of measure to reduce government spending is a loose sort of “pay for performance” scheme for hospitals, in which Medicare hospital payments are reduced slightly to fund incentive payments for high-


\textsuperscript{88} See PPACA § 3401, 124 Stat. at 480.

\textsuperscript{89} Id. § 10606, 124 Stat. at 1006.

\textsuperscript{90} Id. § 6001, 124 Stat. at 684, amended by § 10601, 124 Stat. at 1005, amended by HCERA, Pub. L. No. 111-152, § 1106, 124 Stat. 1029, 1049 (2010). The so-called “Stark Bill” was designed to prevent the conflict of interest that could result from physicians owning hospitals to which they could admit patients. See MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, THE LAW OF HEALTH CARE FINANCE AND REGULATION 592 (2d ed. 2008).


\textsuperscript{92} PPACA § 6001, 124 Stat. at 684, amended by § 10601, 124 Stat. at 1005, amended by HCERA § 1106, 124 Stat. at 1049 (adding 42 U.S.C. § 1395nn(i)(1)(a)(i), which permits whole-hospital ownership only where that ownership already existed on December 31, 2010).

\textsuperscript{93} Id. § 6002, 124 Stat. at 689.

\textsuperscript{94} Id. § 6402(i), 124 Stat. at 760.
"High-performance" is left to HHS's discretion, but must include efficiency measures, "including measures of 'Medicare spending per beneficiary.' " The ACA also reduces payments to hospitals with "excess readmissions"—that is, patients being readmitted to the hospital due to poor care—and to hospitals in the risk-adjusted top quartile for health care acquired conditions. Additionally, certain groups of providers, including physicians and hospitals, will be permitted to function as "Accountable Care Organizations." Any ACO which manages to lower costs will be permitted to keep some of the savings rather than passing them all along to Medicare, provided that quality does not fall.

The ACA also includes a variety of pilot programs and experiments aimed at reducing costs for the government. For example, the legislation authorizes HHS to begin pilot payment bundling and pay-for-performance programs.

In the case of payment bundling, HHS is authorized to expand the pilot so long as it expects quality of care to improve. Additionally, HHS is authorized to award five-year "demonstration grants" to states to develop "alternatives to current tort litigation" relating to health care. Hopefully, successful programs will be presented to Congress for wider consideration.

Finally, to further reduce costs, the ACA authorizes the creation of an Independent Payment Advisory Board (IPAB) comprised of fifteen voting members appointed by the President. The IPAB is designed to have "a mix of

95. Id. § 3001, 124 Stat. at 353.
96. Id. § 3001(a), 124 Stat. at 355.
97. Id. § 3025, 124 Stat. at 408.
98. Id. § 2702, 124 Stat. at 318. Hospital acquired conditions are defined by the Social Security Act as "conditions that could reasonably have been prevented through the application of evidence-based guidelines." 42 U.S.C. § 1395ww(d)(4)(D)(iv)(III) (2006).
100. Id.
101. Id. § 3023, 124. Stat. at 399, amended by § 10308, 124 Stat. at 941 (establishing "a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services").
102. Id. § 10326, 124 Stat. at 961 (specifying only that the pilot must test a "value-based purchasing program for payments").
103. Id. § 10308(a)(2), 124 Stat. at 941.
104. Id. § 10607, 124 Stat. at 1009.
105. Id. § 3403, 124 Stat. at 489 (creating the "Independent Medicare Advisory Board"), amended by § 10320, 124 Stat. at 949 (designating a name change). For an overview of the subject, see generally Timothy Stoltzfus Jost, The Independent Medicare Advisory Board, 11 Yale J. Health Pol’y L. & Ethics 21 (2011).
different professionals” including health economics experts, physicians, and others. The IPAB, intended to “reduce the per capita rate of growth in Medicare spending,” would develop “detailed and specific proposals” and submit those proposals to MedPAC, HHS, the President, and Congress. These proposals “shall not include any recommendation to ration health care, raise revenues . . . or otherwise restrict benefits or modify eligibility criteria.” Certain IPAB recommendations, especially those relating to Medicare Advantage and Part D plans, would be automatically implemented by HHS unless Congress could pass an equivalent savings plan through an expedited process specified by the statute.109

E. Other Provisions

In addition to the four major components discussed in the previous Sections, the ACA also contains several provisions aimed at improving access to health insurance and to medical care more generally. It establishes Exchanges as a sort of insurance marketplace, expands existing government programs such as Medicaid, and expands funding for federally qualified health centers, which provide free or low-cost care.

The ACA requires each state to establish an “American Health Benefit Exchange” or to participate in a multi-state Exchange. Exchanges will ideally perform a valuable informational function for consumers, acting as a database and streamlined resource where consumers can research and purchase insurance plans. These exchanges will start in 2014 and cover individual and small employer markets; in 2017, states may opt to include large group employers as well. Each plan in an Exchange will be required to meet federally-mandated minimum benefit standards. These standards are yet to be determined and remain at the discretion of HHS, although several specific components are specified by the statute.

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106. PPACA § 3403, 124 Stat. at 489.
107. Id.
108. Id. There would be no proposal requirement in the event of certain findings about per capital growth rate by the Chief Actuary. Id.
110. Id. § 3403(a)(1), 124 Stat. at 495-99.
111. Id. § 1311(a), 124 Stat. at 173.
112. Id. § 1311(f), 124 Stat. at 179. Any multi-state exchange is subject to HHS approval; HHS thus retains implicit authority to force a state to form its own exchange. Id.
113. Id. § 1311(b)(1), 124 Stat. at 173.
115. Id. § 1311(d)(2)(B)(i), 124 Stat. at 176 (“An Exchange may not make available any health plan that is not a qualified health plan.”).
noted. While states will be permitted to set higher standards, they will also be required to pay the premium difference for any individual who receives federal subsidies.

Exchange plans are to be sorted according to “actuarial value”: the percentage of projected medical expenses covered by a given plan. A “Bronze” plan has an actuarial value of 60%, and each additional tier increases that percentage: Silver (70%), Gold (80%), and Platinum (90%). HHS will “rate” each plan “on the basis of relative quality and price,” and will post its rating online, accompanied by enrollee satisfaction data. Any insurer that seeks Exchange certification must justify any price increase to the Exchange, usually run by a state government. Exchanges, however, are not permitted to exclude a plan by using price controls, and are expressly prohibited from rationing life-saving medical treatments. Exchanges will have a standard format for displaying health benefits plan options, calculators to incorporate any federal subsidies, and other tools. Exchanges will also identify individuals whose employers did not provide insurance and report them to the IRS, thus subjecting the employers to a penalty. The federal government will also oversee and negotiate contracts for at least two multi-state plans through the Office of Personnel Management, and at least one of these plans must be financed by a non-profit insurer.

116. See supra text accompanying note 46. PPACA repeats the requirement for mental health parity in § 1311(j), 124 Stat. at 181.
119. PPACA § 1302(d), 124 Stat. at 167.
120. Id. § 1311(c)(3), 124 Stat. at 175.
121. Id. §§ 1311(c)(3)-(5), 124 Stat. at 175. Section 1311(c)(3) appears to have a minor error, denoting the Internet portal as being established in § 1311(c)(4); it is actually established in § 1311(c)(5), 124 Stat. at 175, which references § 1103, 124 Stat. at 146.
122. Id. § 1311(e)(2), 124 Stat. at 178.
123. Id. § 1311(e)(1)(B)(ii), 124 Stat. at 178.
124. Id. § 1311(d)(4)(G), 124 Stat. at 177.
125. For example, the Exchange must have a toll-free hotline, an Internet website, rating information, and information about the mandate. Id. § 1311(d)(4), 124 Stat. at 176-77.
126. Id. § 10104(q), adding § 1334, 124 Stat. at 902-903. These plans are not government-financed, and thus are different from the “public option” that was under consid-
ADVERSE REACTIONS

The ACA also expands Medicaid and other direct government provision of insurance. First, it requires that states extend Medicaid to all non-elderly individuals with incomes up to 133% of the FPL, thus removing all previous non-income qualifications. The simplicity of this change almost disguises its importance, but it is extremely valuable for the applicable population. Second, the ACA provides 23% in additional federal funding for the Children’s Health Insurance Program (CHIP) for the years 2016-2019. Third, over the next ten years the ACA closes a gap in Medicare prescription drug coverage—the famous “donut hole”—by lowering beneficiary coinsurance in that range from 100% to 25%.

Finally, the ACA attempts to increase access to medical care independent of insurance status. It expands funding for Community Health Centers, defined previously by the Public Health Service Act as being designed to reach medically underserved populations, with particular emphasis on migrant workers, the homeless, and residents of public housing. Community Health Centers are required to adjust discounts “on the basis of the patient’s ability to pay,” making them a valuable resource for the impoverished and uninsured. The ACA also requires tax-exempt hospitals to provide lists of standard charges, to adopt and publicize a financial assistance policy, and to bill qualifying patients no more than “the amounts generally billed.”

II. THE ARCHITECTURE OF REFORM

The basic features of the ACA—the ban on health status discrimination, the mandate, the subsidy, and the fine—each play a central role in ensuring that all citizens, regardless of any preexisting conditions, have reliable access to stable

131. Id. § 2101, 124 Stat. at 286, amended by § 10203(c)(2)(a)(i), 124 Stat. at 928.
132. See Duff Wilson, Filling the Donut Hole, N.Y. TIMES, Mar. 20, 2010, at A10 (explaining that HCERA eliminates the Medicare Part D “donut hole” which excludes coverage for drugs purchased between annual spending levels of $2,830 and $6,300).
136. Id. § 254b(k)(3)(G)(i).
health insurance. The prohibition on health status discrimination would fail without a mandate; a mandate requires subsidies; subsidies must be funded with revenue provisions. Part II examines each of these elements in turn.

A. Solidarity Insurance and Community Rating

Restricting health status discrimination addresses the question of the very purpose of insurance. In an unregulated market, insurance is fairly simple. Risk-averse individuals purchase insurance to ameliorate risk, paying slightly more than they expect to gain in insurance payouts, which in turn allows the insurer to pay overhead costs and collect profits. Market-based insurance is not designed to help people buy things they could otherwise not afford; it is meant to make their finances predictable. Insurance distributes risk rather than expense. Crucially, that risk must be distributed across a pool of policyholders which, ex ante, appears identical. If some individuals are predictably higher-risk, the low-risk population will break off to form a new pool in which they will pay lower premiums. Insurance pools thus tend to segregate, with high-risk patients paying higher premiums because they are consistently excluded from low-risk, lower-premium pools.

Historically, the insurance industry has operated as predicted by this model. As Professor Mary Crossley explains, “[d]iscrimination against unhealthy persons is deeply ingrained” in health insurance, and is “generally accepted as a legitimate application of risk-classification.” Any single insurer that insures a high-risk pool will incur losses as it pays the health care costs of the less-healthy patients. If the insurer increases rates to cover costs, it will incur further losses as healthy policyholders flee to lower-premium insurers. Rescission, the practice of withdrawing coverage after a policyholder becomes ill, is a disconcerting industry practice but also a fairly predictable economic result of market insurance. Rescission is, simply put, insurance companies removing...
high-risk policyholders in order to keep premiums low. To President Obama and democratic leaders in Congress, this segregation of policyholders contradicts the very purpose of health insurance, which is not actuarial fairness, but “social solidarity.” In their vision, “healthy persons subsidize the care received by unhealthy persons . . . .”

Indeed, stories of people who are denied life-saving medical care precisely when they need it the most are profoundly troubling, as is the prospect of people who cannot purchase insurance in the first place. Accordingly, the ACA prohibits denials, rescissions, and discriminatory pricing. A normal market pushes insurers to charge an experience rate based on that individual’s past experience. The ACA forces insurers to charge a community rate: a consistent premium that ignores health status and provides insurance access to even the sick and the disabled. Restricting discrimination in health insurance markets however, exacerbates another problem: adverse selection.

B. Adverse Selection and the Mandate

The dilemma between equalized access and adverse selection has always threatened health insurance, but it becomes particularly poignant when community rating is implemented. The mandate is the ACA’s attempt to solve this problem. Adverse selection stems from asymmetric information, a particularly severe problem in medical economics and one of the dominant justifications put forth for government intervention. Asymmetric information results from the fact that “[t]he buyers [of insurance policies] know more about their own health than the sellers.” Thus, when an insurer uses cost projections to set its premiums, it runs the risk of “attracting a special subset of the population with unusually high health care costs.” As insurers attempt to avoid bad

their own coverage; misrepresenting insureds pay a portion of everyone else’s actuarially fair premiums.”

Crossley, supra note 10, at 78 (describing advocates of actuarial fairness as believing that “each individual should bear financial responsibility for his own risk of incurring medical expenses”).

Id. at 73.

Id.

See Obama, supra note 7.

See supra Section I.A.


Id.
health risks, the result is a “frenzy of sickly people seeking coverage and healthy people trying to evade sickly people.” Insurers who fail to avoid unhealthy patients are predicted to incur excess costs, drive off healthy consumers, and fall into an insurance “death spiral.”

Insurance plans usually cohere because the transaction costs associated with employer-based insurance prevent too much movement in insurance markets. But the ACA’s imposition of community rating would exacerbate adverse selection—not least because people can now wait until after becoming sick, then purchase insurance without penalty. The most obvious way to address the problem is to impose a law that prevents good risks from fleeing. Such a law could take the form of an incomplete mandate that prohibits insurance packages that omit certain benefits. These types of mandates, unlike the mandate in the ACA, do not require individuals to purchase insurance, but those who do so must buy a certain amount of coverage. While incomplete mandates prevent good risks from fleeing to a low-coverage plan, they also push these individuals to exit the insurance market entirely. This results in numerous individuals who either self-insure or, as then-Professor Lawrence Summers and the President each described, force others to bear the costs of their care. Instead, therefore, the ACA imposes a complete mandate, which requires every-

151. Id.


154. See Lawrence H. Summers, Some Simple Economics of Mandated Benefits, AEA PAPERS AND PROCEEDINGS, May 1989, at 179. Summers’s examples of adverse selection involve healthy employees fleeing employers who offer too-expensive insurance, but the same idea applies to insurance plans more broadly. See id. at 179 n.1.

155. Id. at 178 (referring to “the externality that arises from society’s unwillingness or inability to deny care completely to those in desperate need, even if they cannot pay”).

156. See Obama, supra note 7 (“If there are affordable options and people still don’t sign up for health insurance, it means we pay for these people’s expensive emergency room visits.”). But see infra notes 228-230 and accompanying text (arguing that the President’s point is not persuasive).
ADVERSE REACTIONS

...one to purchase insurance. Incomplete mandates regulate underinsurance, but the ACA regulates uninsurance.

The ACA’s mandate was designed to solve adverse selection, but it raises a problem of its own: What should be done about those who cannot afford insurance? It is possible, of course, to build in a hardship exemption, and the ACA does so.157 But instituting the hardship exemption alone is self-defeating: Medical costs have been rising steadily over time and eventually the exemption could conceivably cover a large proportion of the American population. Here, too, the ACA attempts to provide a solution.

C. Expenses and Subsidies

In order to make the mandate possible, the ACA also had to address the expense of health insurance, which has been growing over time. Between 1999 and 2008, the cumulative increase in health insurance premiums was 119%, compared with cumulative inflation of just 29%.158 In New York, the highest-cost state, a family plan now costs an average of $13,296.159 In light of costs like these, a mandate compelling a family to buy insurance seems politically unsustainable. The ACA thus imposes the most direct solution: a subsidy. As described earlier,160 the ACA’s subsidies function, from a consumer’s perspective, as price caps. A family making 400% of the poverty level, for example, pays a maximum of 9.5% of its income in premiums, indexed to medical inflation.

Even without considering the mandate, subsidies also serve an important function in helping protect families from the expenses of medical care. Professor Elizabeth Warren, now in the Obama Administration, and other scholars have published statistics arguing that more than half of bankruptcies are caused by medical-related phenomena.161 Most recently, Professor David Himmelstein has argued that 62% of bankruptcies can be traced to medical problems.162 The

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159. Ctr. for Pol’y and Research, supra note 28, at 6 tbl.3.

160. See generally supra Section I.C.

161. See, e.g., David Himmelstein, Elizabeth Warren, Deborah Thorne & Steffie Woolhandler, Marketwatch: Illness and Injury as Contributors to Bankruptcy, Health Aff., Feb. 2, 2005, at W5-63, W5-66, available at http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63.full.pdf (“Slightly more than half (54.5 percent) ... met criteria for ‘any medical bankruptcy.’”).

findings in these studies, although controversial, have been highly influential. Congress inserted Professor Warren's findings, for example, into the text of the bill itself. In particular, these studies argue that health insurance can be insufficient to stem these financial disasters, sometimes because out-of-pocket costs are too high and sometimes because families lose insurance after the onset of illness. Between deductibles, co-pays, and coinsurance, many families fall into financial hardship despite the presence of insurance. Even routine medical bills, Professor Melissa Jacoby argues, can push families into bankruptcy. These cost-sharing provisions may cause even insured families to ration needed medical care, exacerbating underlying problems and increasing overall medical expenses. This defeats the solidarity purpose of health insurance: to help provide medical care for those who most need it.

Accordingly, the ACA imposes a cost-sharing cap on insurance plans: After a policyholder has spent $2,250 in out-of-pocket expenses ($4,500 for a family), the insurance plan cannot impose any further cost-sharing. Still, for many families, $4,500 is a significant burden. The ACA therefore also provides government subsidies for cost-sharing to prevent the “underinsurance” problem that so many bankruptcy articles raise. For families with incomes between 100% and 400% of the FPL, the government pays for 70-94% of their out-of-pocket expenses, thereby dramatically reducing the burden of features like co-pays and deductibles, which can push consumers to self-ration.

163. See, e.g., David Dranove & Michael Millenson, Medical Bankruptcy: Myth Versus Fact, HEALTH AFF., Feb. 28, 2006, at W74, W78, available at http://content.healthaffairs.org/content/25/2/w74.full.pdf. Unfortunately, a more detailed examination of the controversy is beyond the scope of this Note.

164. See Obama, supra note 7 (“Everyone in this room knows what will happen if we do nothing. . . . More families will go bankrupt.”).


166. See Himmelstein et al., supra note 161, at W5-69 (claiming that among “medical debtors . . . three-fourths (75.7 percent) of these debtors were insured at the onset of the bankrupting illness. . . . Three-fifths (60.1 percent) initially had private coverage, but one-third of them lost coverage during the course of their illness”).

167. Melissa B. Jacoby & Mirya R. Holman, Managing Medical Bills on the Brink of Bankruptcy, 10 YALE J. HEALTH POL’Y L. & ETHICS 239, 246 (2010) (“Contemporary studies continue to report that cost-sharing results in delinquent medical debt with some prevalence, even for routine care.” (citations omitted)).

168. See id. at 247 n.30.


170. See supra Table 2.
ADVERSE REACTIONS

Subsidies solve the problems caused by the mandate by making health insurance and cost-sharing affordable. And yet they create their own problem: The government must pay for them.

D. Deficits, Taxes, and Spending Cuts

In order to pay for subsidies and other costly elements of the ACA, the government imposed a series of new taxes, including some prominent industry taxes and a “Cadillac tax.” Additionally, it reduced a variety of Medicare expenditures. These measures were probably implemented to preempt concerns about exacerbating the deficit, but they were also required by law. In February 2010, President Obama signed into law the PAYGO Rule, establishing that no new tax cuts or government spending provisions could be enacted without a corresponding tax increase or spending reduction.171 In other words, the “pay-as-you-go” rule prohibits any legislative package that would, on balance, worsen the deficit.172

The ACA imposes a variety of new spending measures, including subsidies and Medicaid expansions. To comply with PAYGO Rules, Congress included several revenue-raising provisions in the ACA to ensure that CBO could project a deficit reduction. The results of CBO’s analysis are displayed in Table 3:

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172. CBO specifically notes that “pay-as-you-go procedures would apply” to PPACA and HCERA. See Letter from Cong. Budget Office to Nancy Pelosi, supra note 13, at 4.
Table 3: CBO Estimated 2010-2019 Deficit Effects (in billions of dollars, with negative numbers denoting deficit reductions)\textsuperscript{173}

<table>
<thead>
<tr>
<th>Spending Increases</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium and Cost Sharing Subsidies</td>
<td>350</td>
</tr>
<tr>
<td>Medicaid and CHIP Expansions</td>
<td>434</td>
</tr>
<tr>
<td>Exchange-Related Spending</td>
<td>7</td>
</tr>
<tr>
<td>Other Changes in Direct Spending</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spending Decreases</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Physician Fee For Service Schedule</td>
<td>-332</td>
</tr>
<tr>
<td>Medicare and Medicaid DSH Payment Reductions</td>
<td>-36</td>
</tr>
<tr>
<td>Other Medicare, Medicaid, and CHIP Provisions</td>
<td>-87</td>
</tr>
<tr>
<td>Decreased Reimbursement for Community Living Assistance Services</td>
<td>-70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increases in Tax Revenue</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandate Fine</td>
<td>-65</td>
</tr>
<tr>
<td>“Cadillac Tax”</td>
<td>-32</td>
</tr>
<tr>
<td>Associated Effects of Coverage Provisions</td>
<td>-46</td>
</tr>
<tr>
<td>Industry Fees</td>
<td>-107</td>
</tr>
<tr>
<td>Hospital Insurance Tax</td>
<td>-210</td>
</tr>
<tr>
<td>Other Revenue Provisions</td>
<td>-103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decreases in Tax Revenue</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidies via Premium Tax Credits</td>
<td>144</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Change in Deficit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-123</td>
</tr>
</tbody>
</table>

CBO’s estimates indicate that the ACA’s tax increases and spending decreases sufficiently cover the increased expenditures of health reform and even reduce the deficit. It is important to note that CBO’s estimates do not project any overall reductions in medical spending from preventive care measures.

\textsuperscript{173} See id. at tbl.2.
In exchange for the $965 billion in projected additional federal spending,\textsuperscript{174} CBO estimated that an additional 32 million people would gain health insurance, as displayed in Table 4:

Table 4: CBO Estimates on Changes in Insurance Coverage by 2019 (in millions of uninsured people)\textsuperscript{175}

<table>
<thead>
<tr>
<th>Program</th>
<th>Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid and CHIP</td>
<td>+16</td>
</tr>
<tr>
<td>Employer</td>
<td>-3</td>
</tr>
<tr>
<td>Nongroup and Medicare</td>
<td>-5</td>
</tr>
<tr>
<td>Exchanges</td>
<td>+24</td>
</tr>
<tr>
<td>Total Uninsured</td>
<td>-32</td>
</tr>
</tbody>
</table>

CBO’s estimates, then, accord with the President’s stated desires. The ACA prevents rescission; reduces the ranks of the uninsured through Medicaid expansions and subsidies; and, according to CBO, reduces federal deficits.

One major source of revenue is the so-called “Cadillac tax,” which CBO projects will raise about $32 billion.\textsuperscript{176} The tax also aims to slow the rising costs of medical care. The excise tax is intentionally indexed not to medical inflation, but to general consumer inflation plus 1%.\textsuperscript{177} If health premium growth continues to outpace general inflation by more than 1%, a greater proportion of plans will fall into the “Cadillac” territory over time.

Part of the explanation for perpetually rising costs is that they are subsidized by the income tax system. Employer-provided health insurance provides value for the employee but is not taxed the way other income would be. Health insurance becomes “cheaper than any other good or service the employee might buy, because [it] is purchased with before-tax dollars.”\textsuperscript{178} The Cadillac tax

\textsuperscript{174} See id.

\textsuperscript{175} Id. at tbl.4. This would work out to a cost of roughly $30,000 per additional insured person, except that much of the spending is devoted to purposes other than decreasing uninsurance. The $30,000 per person estimate is thus too high. It is difficult, however, to separate out the effects precisely—for example, many of the subsidies will make insurance more affordable for families who are currently insured.

\textsuperscript{176} See supra Table 3.


\textsuperscript{178} Phelps, supra note 149, at 345. This tax subsidy was estimated to cost as much as $90 billion in 1994. Id. at 350. It is surely much higher today.
begins to remedy this distortion by closing the loophole, starting with the most expensive plans and gradually expanding to encompass more and more of them, thus pressuring insurance plans to become less generous. As David Leonhardt of the *New York Times* explains: “The cost of insurance could rise. Or perhaps more likely, companies would stop offering such generous plans. . . . Would that be so bad?”179 If this tax functions as designed, employees will shy away from high-cost plans.180 As a result, the most expensive benefits would probably be dropped from most plans without harming actual health.181 In the long run, any money saved will hopefully take the form of higher wages.182

Current tax benefits effectively provide a government subsidy, and so are artificially raising expenditures on health care. As Leonhardt argues, “It encourages wasteful spending – the extra M.R.I., the brand-name drug that’s no better than a generic, the cardiac-stent procedure that has no evidence of extending life. . . .”183 If Leonhardt’s analysis is right, inflated insurance plans, which lead to excess demand for medical services, would be dramatically reduced. Accordingly, the Cadillac tax may accomplish much more than deficit reduction—it will likely slow medical spending as a whole and thus save money for Medicare, Medicaid, and the private sector.184 If it succeeds, the excise tax will make insurance more affordable not just for individuals, but for the nation as a whole.


180. Id.

181. Id. (“People with Cadillac plans aren’t healthier than people with merely good insurance . . . .”).

182. Id. (“[W]age increases are often meager when insurance premiums are growing quickly . . . .”). Concerned about this possibility, PPACA actually instructs a commission “to determine whether employees’ wages are reduced by reason of the application of [the fines from the employer mandate] . . . .” PPACA § 1513(c), 124 Stat. at 256. This is, of course, not quite the same as studying whether insurance costs cause wages to decrease.

183. Leonhardt, supra note 179.

184. Professor Greg Mankiw, formerly a key member of President George W. Bush’s Council of Economic Advisors, agrees, calling the Cadillac tax “a reasonable policy from the standpoint of economic efficiency . . . .” Greg Mankiw, *The Incidence of the Cadillac Tax*, GREG MANKIW’S BLOG (Oct. 13, 2009), http://gregmankiw.blogspot.com/2009/10/incidence-of-cadillac-tax.html. Mankiw also points out, however, that it “very clearly breaks President Obama’s ‘read my lips, no new taxes unless you’re rich’ campaign pledge.” Id.
E. The Philosophical Core and Political Robustness

As the previous Sections establish, the core of the ACA lies in four essential components. The legislation begins with provisions enforcing community rating by prohibiting health status discrimination. Community rating exacerbates adverse selection, and so the ACA imposes an insurance mandate. The mandate would be politically unsustainable without subsidies, so the ACA provides them. Subsidies are expensive and, if funded through deficit spending, would violate PAYGO, so the reform package includes a variety of spending offsets and tax increases.

Whether by accident or design, community rating strengthened the political prospects of the bill. Even when support for the bill as a whole was lukewarm, the bill’s central provision prohibiting insurers from discriminating on the basis of preexisting conditions has always been strongly supported. And if Americans truly support the central purpose, then the other three pieces must follow in sequence. Community rating must be accompanied by a mandate, subsidies, and revenue provisions. Opponents may tinker around the edges, but fundamentally the ACA originates from a place of political strength. That strength served as advocates’ rhetorical base during public debates and helped catalyze the bill’s passage. The ACA may seem like a mishmash of unrelated ideas, but it was specifically designed around one simple idea: Insurers should treat the healthy and the sick alike.

III. Paved with Good Intentions

The framework above depicts the ACA’s intended effects, but its probable effects are another thing entirely. Will reform really lower costs, expand access, and provide security? While a great deal of the legislation’s ultimate shape has yet to be determined, it appears that the ACA will be inadequate to accomplish its objectives for at least four major reasons. First, insurance “cherry-picking” will remain a viable strategy. Second, the rising price of insurance will undermine the effectiveness of the mandate, and many healthy individuals may forego insurance and simply pay the fine instead. Third, health insurance on its own is insufficient to ensure the delivery of actual medical care, and the ACA may decrease rather than increase access to physicians. Fourth, the ACA is likely to increase the deficit dramatically; even the CBO considers its own budget


186. See generally Obama, supra note 7 (noting that the effort “[has] been supported by an unprecedented coalition of doctors and nurses; hospitals, senior groups, and even drug companies . . . .”).
estimates to be naïve.\textsuperscript{187} Most strikingly, the interdependent nature of the ACA’s central provisions means that remedying any particular problem would likely exacerbate the others. Part III examines each of these difficulties in turn.

\section*{A. Solidarity and Insurance Gamesmanship}

The central provision of the ACA appears, at first glance, to be its most robust. Insurers may no longer reject or charge higher premiums to those with preexisting conditions. However, more subtle forms of discrimination remain on the table, and there is now more incentive to engage in them. According to health economist Mark V. Pauly, the ACA “probably increase[s] the incentive for cherry-picking” since insurers cannot charge higher premiums to the unhealthy anymore.\textsuperscript{188}

And, indeed, several tools to screen out the unhealthy remain viable. While a great deal will depend on HHS’s decisions regarding essential health benefits, insurers are very experienced in subtle forms of screening potential policyholders. For example, insurance companies often offer gym memberships, which is valuable only to those healthy enough to use such equipment.\textsuperscript{189} Health insurers are also sometimes uncooperative on insurance claims, behavior which disproportionately affects the chronically ill.\textsuperscript{190} Even insurance plans marketed to the elderly tend to offer benefits that attract low-risk patients: health club membership, eyeglasses, and preventive dental care.\textsuperscript{191} The ACA prohibits none of these techniques. And while the ACA forces insurance plans to pay for certain expensive treatments such as dialysis, nothing in the statute as written forces them to employ a reasonable number of physicians who can provide that treatment.\textsuperscript{192}

A great deal also depends on what HHS defines as an “essential benefits package.”\textsuperscript{193} Professor Jessica Mantel has argued that adverse selection will force most plans down to this minimum essential benefits package.\textsuperscript{194} Because most

\begin{enumerate}
\item See infra text accompanying notes 273-277.
\item See id.
\item Id.
\item Id. Of course, a private insurance company’s internal policies—or future HHS regulations—might require certain staffing levels.
\item See Jessica Mantel, Setting National Coverage Standards for Health Plans Under Healthcare Reform, 58 UCLA L. REV 221, 224 (2010) (”[O]nly individuals who anticipate needing treatment for these conditions would purchase the supplemen-
plans will only cover the minimum, Professor Mantel argues that the political process will lead to a high floor. Patient lobbying groups will demand coverage for their conditions and, more troublingly, provider lobbying groups (such as chiropractors or fertility specialists) may demand coverage to ensure demand for their services. Expanded services, of course would drive up costs. It would also, however, prevent certain types of screening. If every plan offers, say, a gym membership, then insurers cannot use such items to screen out undesirable policyholders. Even without altering benefits, however, insurance plans can use other ways to screen. The names of the plans themselves can become slogans targeted at particular audiences. Anthem Blue Cross offers a line of policies known as “Part-Time Daredevil” and “Thrill-Seeker” that it advertises with the slogan “You’re young. You’re healthy. You’re in shape.” Insurance companies could market themselves among younger demographics. Small fonts, offices without elevators, and agents who operate exclusively out of areas with “desirable” demographics could also become standard practices.

As screening becomes more important in light of community rating, insurers may take advantage of technology to market towards a healthier pool. Companies could market themselves through social networks like Facebook or Twitter or with smartphone applications. Applications that require bandwidth-heavy technologies such as Flash could deter those without reliable Internet access, and “captcha” technology, a security device designed to screen out automated software, could be employed to screen out those who type slowly, have trouble reading, have weak English skills, or are unfamiliar with computers.

Whether the ACA actually succeeds in implementing meaningful community rating and Crossley’s solidarity model will depend on many factors, includ-
ing the composition of minimum essential benefits.\textsuperscript{201} Again, however, a too-successful implementation of community rating risks pushing healthy populations to opt out of insurance altogether. If insurers are charging a healthy person the same rate as an unhealthy one, the healthy individual will have an incentive to opt out, pay the fine, and wait until after illness strikes to purchase a policy. The mandate was designed precisely to deal with this scenario.

\textbf{B. The Mandate: Fines, Premiums, and Civic Duty}

If HHS is pressured to establish a high-benefit insurance package as a result of this legislation, as Mantel fears, then more and more healthy Americans will likely drop insurance entirely. Premiums will continue to rise for diminishing marginal gains, which, after a certain point, will compel many individuals to drop coverage. The mandate is designed to prevent this flight from insurance. If premiums rise high enough, however, the fine may be too low to deter unraveling.

At least one Wall Street blog analyzed the changes and came up with the following conclusion: “This one’s easy…. Drop all coverage….. This is the only logical action to take…..”\textsuperscript{202} The author strongly urged readers to short sell every major health insurance company on the theory that they would be pushed into bankruptcy.\textsuperscript{203} The blog was incorrect as to the magnitude of the fine,\textsuperscript{204} a potentially serious error, but the underlying premise remains valid. The author predicted very large premium increases\textsuperscript{205} on par with those seen prior to credit card rate regulation,\textsuperscript{206} and accordingly urged readers to drop health care coverage until after they become ill.\textsuperscript{207}

\begin{thebibliography}{9}
\bibitem{201} HHS has suggested that it will begin the process of establishing the relevant regulations towards the end of 2011. See N.C. Aizenman, ‘Essential Benefits’ a Complex Question in New Health-Care Law, Wash. Post, Post Politics, Jan. 14, 2011, http://www.washingtonpost.com/wp-dyn/content/article/2011/01/14/AR2011011406172.html.
\bibitem{203} Id. (“[T]his is the end of the health industry in America…. I cannot stop this idiocy but I can sure attempt to profit from it.”).
\bibitem{204} Id. The original argument was based on a mandate fine of $750. The argument was subsequently revised with a fine that is “a sliding scale [amounting to] 2\% of your AGI” which is still incorrect. Id.
\bibitem{205} Id. (“The ‘cheapest’ acceptable policy will cost somewhere around $15,000 for a single person, and over $20,000 for a family. This is, for most people, more than five times the maximum possible fine ….” (emphasis omitted)).
\bibitem{206} Id. (“This is precisely what the banks did in front of the CARD act becoming effective, and it will happen here as well.”).
\bibitem{207} Id. (“If you have a catastrophe of any form, buy the insurance at that point in time. You cannot be turned down or charged more.” (emphasis omitted)).
\end{thebibliography}
Unfortunately, it is not yet clear what the eventual cost of health insurance will be, partly because HHS has not yet established the package of minimum essential benefits. In a tentative January estimate, CBO estimated that a Bronze family plan, already a low-benefits package, would probably average more than $12,000—approximately $6,000 more than the current national average.

This projection, roughly speaking, is not ridiculous. As the subsidy and the fine push families to buy insurance, simple supply and demand economics predicts that the price of plans will increase. More importantly, if insurers are not allowed to discriminate against the unhealthy, their own costs are likely to increase and premiums will have to rise accordingly. Real-world experience confirms the theory. When the state of New York imposed a similar nondiscrimination requirement, premiums in that state spiked to the highest in the nation. An individual market family plan in New York averages $13,296. New York does not have a mandate, but Massachusetts, which does, has the second highest average premium in the country. The average Massachusetts family plan costs $13,288. The average premiums in these two states are much more expensive than plans in other states. For example, the state with the fourth-most expensive family plan, Connecticut, has an average family plan of just $8,477. CBO’s projections, therefore, seem correct or even optimistic—

Denninger notes the risk of a “zero-notice catastrophe,” but urges readers to self-insure.  

208. For an explanation of a “Bronze” plan, see supra text accompanying notes 118-119.


210. CTR. FOR POL’Y AND RESEARCH, supra note 28, at 4 (finding the national average to be $6,328 in 2009).

211. See Hartocollis, supra note 152 (“Healthy people, in effect, began to subsidize people who needed more health care. The healthier customers soon discovered that the high premiums were not worth it and dropped out of the plans. The pool of insured people shrank to the point where many of them had high health care needs.”).

212. CTR. FOR POL’Y AND RESEARCH, supra note 28, at 6.


214. CTR. FOR POL’Y AND RESEARCH, supra note 28, at 6 tbl.3.

215. Id. Maine is the fourth-most expensive state according to table 3, which ranks by the price for a single person (as opposed to the price for a family). Id.

216. It is unclear how CBO calculated its projections. It seems to have assumed roughly a 100% premium increase over the course of 7 years, which would be similar to the 131% rise in premiums for employer-provided health insurance between 1999 and 2009. See Kaiser Family Found., Employer Health Benefits 1 (2009),
federal law will soon resemble the law in New York and Massachusetts, and it is thus reasonable to expect that insurance costs will be roughly similar.

Will families simply pay the mandate fine? It is difficult to say, because extrapolation is nearly impossible in this scenario. Still, a rough estimate makes clear that the ACA’s attempt at reform is in very dire straits. Assuming that health insurance is currently priced according to demand, families are generally gaining about as much benefit from their insurance plans as they pay in premiums. Increasing their premiums gives them an incentive to drop coverage while imposing a fine gives them incentive to keep it. But the incentive to drop insurance, in this analysis, is stronger than the incentive to keep it unless a family is making more than $258,700 a year.217 Moreover, the ACA explicitly states that failure to pay the fine cannot result in criminal prosecution, liens, or levies.218 Finally, if CBO’s estimates are correct, many families will fall into the hardship exemption; an insurance plan that costs $12,000 a year would not

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217. This calculation is highly dependent on other estimates, but is conceptually simple enough. If healthy families are gaining about $6,000 worth of benefit from their $6,000 plan, and if they gain no more from a $12,000 plan, then they will be paying an excess of about $6,000, meaning they would be better off dropping insurance until their fine reaches about $6,000. The fine is calculated as 2.5% of income above a threshold amount of $18,700. See supra note 42 and accompanying text. The fine thus reaches $6,000 when family income is $258,700. Most families probably have some excess gains from their current insurance plans, but the $12,000 estimate will be for a Bronze plan that is likely to drop some elements that families currently find valuable (it is important to remember that the original $6,000 would not disappear for newly uninsured families; they would be able to use it to self-insure). It is difficult to guess which of these two effects will dominate, especially considering that some families are probably overpaying now thanks to the illusion that their employer is actually paying. See Hyman & Hall, supra note 153, at 28 (“[M]ost employees (and some employers) believe that employers are footing the bill for the coverage that employees receive. The result is that employees are relatively indifferent to the cost of their health care coverage ....”). In any case, families may begin to self-insure when hit with a higher premium bill, which again makes the estimate conservative in this respect.

require fines until a family had income of $150,000, making the mandate inapplicable to such families.\footnote{PPACA § 1501(b), 124 Stat. at 247 (establishing the hardship exemption where premiums would exceed 8% of taxable income).}

Put another way, families earning less than $88,200 will usually have some incentive to keep their insurance, since the government will subsidize it.\footnote{The government subsidy would cap premiums at 9.5% of income. See HCERA, Pub. L. 111-152, § 1001(a)(1)(A), 124 Stat. 1029, 1031 (2010); supra text accompanying note 62. For a family making approximately $88,200, 9.5% ($8,379) would still be a substantial increase over current premiums. See supra note 210 and accompanying text.} A family earning more than $244,000 has an incentive to keep insurance, because the fine is much higher than the amount they would spend on premiums. Any family in between, however, would be financially better off by going uninsured, not least because many of them are likely to fall into the hardship exemption.

While families usually do not have precise estimates of the value of their insurance plan in mind, the projected changes in the legislation are very large in magnitude and would certainly catch many families’ attentions, if only in a rough sense.

This analysis is, by necessity, approximate. It depends on a number of assumptions that will almost certainly have to be revisited, but the qualitative ramifications are nonetheless staggering. They are even more frightening for employer-sponsored insurance, where CBO estimates that an average family plan will cost $19,200,\footnote{Letter from Douglas W. Elmendorf to Olympia Snowe, supra note 209, at 3.} approximately $6,000 more than the current national average for employer-provided insurance.\footnote{See Kaiser Family Found., supra note 220, at 1 (finding average annual health insurance premiums to be $13,375 in 2009).} If these numbers turn out to be even remotely close to reality, then insurance markets will completely collapse unless government subsidies manage to prop them up.

There are several potential policy solutions to this issue. If the added revenue from higher premiums will go exclusively towards increasing insurer profitability, then rate regulation will be a viable strategy. It is more likely, however, that higher revenue will be used, at least partially, to cover higher expenses. In that case, draconian premium regulation will simply drive insurers into bankruptcy. A second possible solution is to dramatically escalate the mandate fines. If fines are too high, however, they will be politically unsustainable.\footnote{See Jacob Hacker, Professor of Political Science, Yale Univ., Address to Yale Law School American Constitution Society: What’s Next? Implementing and Expanding the Health Care Law (Apr. 8, 2010) (confirmed in email correspondence with Professor Hacker).} The third solution, as Mantel suggests, is to establish a low mandate floor in order to achieve cost control.\footnote{See Mantel, supra note 194, at 224.} A low mandate floor would result in less-comprehensive
insurance, lower premiums, and thus a relatively stronger mandate. Of course, a low floor would also have the effect of substantially undercovering sick populations and thus undermining the solidarity model that is the driving force of health reform. Fourth and finally, Congress could let the markets collapse and use the resulting political energy to implement a new solution—perhaps a tax-financed public option, or maybe even single-payer health care. If the subsidies continue to rise along with premiums, eventually the government will be paying for most insurance anyway.

If these policy options are not appealing, there is one non-policy option: The administration can make an appeal to social responsibility despite the legislation’s economic inadequacy. Following in President Kennedy’s footsteps, the government could attempt to motivate the American people to see purchase of insurance coverage as a civic duty. However, as Professors David Hyman and Mark Hall observe, “Commentators wax poetic about the social role of health insurance, and treat the decision to offer and purchase such coverage in morally weighted terms. However, the evidence is fairly clear that potential subscribers approach coverage decisions in traditional economic terms.” Can President Obama motivate Americans to see insurance as something more than an economic transaction? Can he persuade citizens that high premiums—much higher than any benefit a healthy person could expect to reap—are a necessary part of social solidarity? Thus far, the President has appealed to an individual’s responsibility to purchase insurance only insofar as it is necessary to cover a person’s own costs:

Even if we provide these affordable options, there may be those—especially the young and the healthy—who still want to take the risk and go without coverage. . . . The problem is, such irresponsible behavior costs all the rest of us money. If there are affordable options and people still don’t sign up for health insurance, it means we pay for these people’s expensive emergency room visits. . . . Unless everybody does their part, many of the insurance reforms we seek—especially requiring insurance companies to cover preexisting conditions—just can’t be achieved.

In addition to whatever spirit of solidarity our national leaders can muster, there is the consideration that some may obey the mandate simply because it is law. For one example of “expressive law,” see Maggie Wittlin, Buckling Under Pressure, 23 Yale J. on Reg. (forthcoming 2011) (manuscript at 3) (on file with author) (“Law affects behavior not only by what it does but also by what it says. By expressing social values, law is able to change social norms and thereby change behavior.”).


See Hyman & Hall, supra note 153, at 26 (emphasis added).

Obama, supra note 7 (emphases added).
ADVERSE REACTIONS

In this speech, President Obama appealed to the young and the healthy to consider their own health expenses, but failed to urge them to conscientiously subsidize high-cost patients. And yet, it is incorrect for the President to demand that healthy individuals purchase insurance to prevent spillover costs to the unhealthy. In our nation, the lowest-spending 50% of the population incurs only 3% of medical expenses, and the highest-spending 5% incurs 50% of the expenses—a per-person difference of more than 150-fold.

Unfortunately for the system as a whole, CBO’s estimates of the price of insurance appear to be roughly correct. The estimates are consistent with the experiences of Massachusetts and New York, and they are actually conservative considering the underlying medical expense distribution. And yet we must hope against all economic sensibility that CBO’s projection proves spectacularly wrong. If not, then the mandate will almost certainly prove inadequate, leaving health insurance to fall into a death spiral of congressionally mandated adverse selection.

C. Expanded Access but Provider Exodus

Even if health insurance manages to cohere, insurance alone will not be enough to ensure improved health. Any health system must also involve actual providers. “What if,” asked one physician recruitment firm, “nearly half of all physicians in America stopped practicing medicine?” This is not going to occur, but the question is rooted in legitimate concerns. The recruitment firm, Medicus, reported in January that “nearly one-third of physicians” surveyed indicated they would “want to” leave medicine if health reform passed. As Medicus points out, physicians are notorious for claiming that they will leave medicine, especially when surveyed in self-selected samples, and the claim has not historically proven true. Medicus nonetheless expresses two concerns. First, if even a small number of physicians exit medicine, this could exacerbate an


230. Id.


232. The recruitment firm itself notes that the prospect is slim. Id. (conceding that “a sudden loss of half of the nation’s physicians seems unlikely”).

233. Id.

234. See id. (“Some experts point to the malpractice crisis of years ago, when many doctors also expressed a desire to leave medicine. Some did quit; many did not.”).
already-projected shortage. Second, “there could be an impact in quality of care due to a lack of morale . . . .”

Even Medicus, however, ignores the most pressing concern of all. Physicians may not be able to exit medicine, but many have already exited the business of caring for government patients. Some have even exited the business of dealing with health insurance entirely. And so even if the ACA successfully provides affordable health insurance, it may still fail at providing actual medical care.

Already, many Medicaid patients report difficulty finding physicians who are willing to see them. The Wall Street Journal reported the story of a 16-year

235. Id. ("The [Bureau of Labor Statistics] predicts a more than a 22 percent increase in physician jobs . . . [by] 2018."). This would be a very severe shortage even before considering any effects of the ACA.

236. Id.

237. See infra text accompanying notes 239-245.

238. See infra note 250.

239. Vanessa Fuhrmans, Note to Medicaid Patients: The Doctor Won’t See You, WALL ST. J., July 19, 2007, at A1 ("[W]hen Medicaid patients seek care, they often find themselves locked out of the medical system."). The problem of Medicaid access has reached particularly severe levels among dental practices. The New York Times reported in 1999 that:

   Even though the vast majority of the poorest Americans, particularly children, are covered by Medicaid for dental care, they are not getting it. . . . Many dentists are reluctant to take patients on Medicaid . . . because the program tends to scrimp on payments and involves a pencil-breaking bureaucracy. Also, Medicaid patients, often with transportation and day-care problems, are much likelier to miss appointments . . . . Then there are what officials diplomatically refer to as "cultural problems . . . ."

Carey Goldberg, Many Dentists Won’t Fix Poor Children’s Bad Teeth, N.Y. TIMES, June 26, 1999, http://www.nytimes.com/1999/06/26/us/many-dentists-wont-fix-poor-childrens-bad-teeth.html; see also Alex Berenson, Boom Times for Dentists, but Not for Teeth, N.Y. TIMES, Oct. 11, 2007, at A1 ("[M]ost dentists want customers who can pay cash or have private insurance, and they do not accept Medicaid patients. As a result, publicly supported dental clinics have months-long waiting lists . . . . In some cases, the results of poor dental care have been deadly."); Jay Reeves, Ala. Dental Spat May Foreshadow Obama Plan Effects, NEWSDAY, April 7, 2010, http://www.newsday.com/news/nation/ala-dental-spat-may-foreshadow-obama-plan-effects-1.1850380 (reporting efforts of private practice dentists to shut down a clinic which cares for Medicaid patients). This may foreshadow the post-reform problems in medical care. See Reeves, supra.

Bizarrely, there are some tentative (and controversial) empirical suggestions that Medicaid patients may fare worse than their uninsured counterparts, even after controlling for baseline health. For a very brief overview, see Scott Gottlieb, Opinion: Medicaid Is Worse than No Coverage at All, WALL ST. J., Mar. 10, 2011, at A17. For somewhat more statistical detail, see Avik Roy, Why Medicaid Is a Humanitarian Catastrophe, APOTHECARY: FORBES BLOG (Mar. 2, 2011, 12:23 PM),
old Medicaid patient with severe joint pain who, despite being publicly insured, had difficulty finding a provider willing to treat her. "When we had real insurance," said her mother, "we could call and come in at the drop of a hat." Such stories are not rare. A 2006 report indicated that half of all physicians polled had either stopped accepting or had limited the number of new Medicaid patients. In Michigan, the number of doctors who saw any Medicaid patients at all fell from 88% in 1999 to just 64% in 2005 and even these Medicaid providers also cap or refuse to accept new Medicaid patients. The director of one of Michigan’s Medicaid plans reports, “We literally get on the phone with doctors and beg.” Some physician groups have even shifted to a “retainer care” model, often referred to as “concierege medicine.” These groups opt out of the insurance business entirely, instead focusing their attention on a smaller number of patients willing to pay a substantial retainer fee.

There are many reasons why doctors avoid Medicaid patients, but the most common explanation is that Medicaid pays such low rates that most physicians cannot afford for a substantial proportion of their patients to be Medicaid patients. Physicians also report trouble dealing with such patients in private practice contexts due to administrative hassles and no-show patients.


240. See Fuhrmans, supra note 239.

241. Id. (emphasis added).

242. Id.

243. Id.

244. Id.

245. See Frank Pasquale, The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response, 7 Yale J. Health Pol’y L. & Ethics 39 (2007). Professor Pasquale’s concern appears to stem from the fact that retainer care is particularly a threat to a vision of solidarity insurance. Id. at 41 (stating that stratification “has already eroded the primary ‘end’ of health insurance: subsidizing the unhealthy, unlucky, and sick . . . . Retainer care threatens to accelerate that process . . . ”). The ACA implements $332 billion in additional Medicare cuts, which might further accelerate the movement of physicians into retainer arrangements. See supra Table 3. But see infra Section III.D (arguing that these cuts are unlikely to materialize).

246. See Fuhrmans, supra note 239 (quoting one physician who takes Medicaid patients: “’[W]e’re the ones getting killed’”).

247. Id.
Some physicians even worry that Medicaid patients are more prone to the sorts of medical difficulties that can lead to malpractice suits.248

The ACA’s Medicaid expansions thus increase the ranks of the insured, but insurance alone does not provide access. Of course, new Medicaid coverage will prove useful for emergently ill patients, but the Medicaid expansions will also exacerbate ongoing access problems. Even patients with low-level Exchange plans might not fare any better than Medicaid patients. If even a moderate number of physicians refuse to accept these patients—either by insisting on other insurance plans, by shifting into retainer care, or simply by quitting—then patient care will actually be harmed, not helped, by the ACA.

Congress could respond in one of a few ways. Already, the ACA has made retainer care more expensive, since retainer care alone will not satisfy the mandate. Congress could also simply force physicians to accept Medicare and Medicaid patients. This is not entirely implausible, since residency training is funded through government outlays and could theoretically be made contingent on some sort of reciprocity agreement.249 But such a move would probably provoke a severe political outcry. In fact, at least one state already appears concerned about the possibility. Missouri Senate Joint Resolution 25 (SJR 25) submitted to voters a state-level constitutional amendment which prohibited any law from compelling a patient, employer, or health care provider to participate in any government or privately run health care system and protected the ability of any patient or employer to pay directly for legal health care services.250 This legislation has no tangible effects since the ACA has no provisions to force providers into government plans and a state constitutional amendment would be helpless to stop federal law anyway. But the sentiment expressed by SJR 25 is unmistakable. Missouri voters are afraid that the ACA will push physicians out of the insurance business, and that Congress may subsequently force them back in.

In order to keep physicians in Medicaid, however, the easiest approach would be for Congress to simply increase Medicare and Medicaid reimbursement while decreasing the hassle associated with these programs. This is probably the simplest, most effective, and most direct approach. Of course, such an


249. For an article advocating precisely such a requirement, see Kevin Grumbach, Fighting Hand to Hand Over Physician Workforce Policy, HEALTH AFF., Sept./Oct. 2002, at 13, 24, available at http://content.healthaffairs.org/content/21/5/13.full.pdf (“Medicare payments came with no strings attached for how many residents could be trained or in which specialties they would be trained.”).

increase would have other budgetary ramifications, which would compound the problems that the ACA is already facing.

D. Deficits: A Wink, a Nod, and the Sustainable Growth Rate

"I said at the beginning of this thing," President Obama reassured a St. Louis crowd, that "we would not do anything that adds to our deficit. . . . This plan does not do anything to add to this deficit." CBO agreed with the President, and yet it seems impossible to extend coverage to thirty-two million more Americans without increasing the deficit. There are several objections to CBO's estimates. First, a bill referred to as the Doc Fix should have been included in the ACA rather than treated separately. Second, CBO's report omits and underestimates other expenditures, partly due to Congressional constraints. Third, CBO correctly does not project any savings that would result from efficiency gains in medical care, despite increased insurance coverage and preventive care delivery. All told, the ACA almost certainly will increase deficits—dramatically.

There has been much attention on the "Doc Fix," an estimated $371 billion of spending increases for physician compensation that was separated from the rest of the ACA. As background, a 1987 law sets strict limits on total physician payments for Medicare and requires scheduled cuts. Since 2002, however, Congress has annually overridden the scheduled cuts on a short-term basis via the so-called "Doc Fix," thus allowing official CBO budget projections to assume that the cuts will in fact be implemented. Annual budgets thus appear to reduce the deficit. The House's July version of the bill included the

251. See infra Section III.D (pointing out that the ACA would have violated statutory "pay-as-you-go" requirements and thus been illegal had such changes been originally present).


253. See supra Section II.D.

254. See infra notes 255-262 and accompanying text.

255. See Tully, supra note 252.


257. Id.

258. Id. Congress's most recent steps actually "allow[ed] an unprecedented 21% cut officially to take effect twice before reversing it," and the stress, Silva reports, is actually pushing some physicians out of Medicare completely, mimicking albeit for different reasons, the provider exodus from Medicaid. Id.; see also supra notes 239-245 and accompanying text. The American College of Physicians had hoped for a permanent solution, with its president Joseph Stubbs stating that "there is
Doc Fix, but it was excised from the Senate version and from the final ACA, and CBO thus omitted it from its estimates. James Capretta, an Office of Management and Budget official in the George W. Bush administration, argued that this was disingenuous: “The bill has many changes in Medicare, but this is the only one Obama wants to do separately. It’s an attempt to hold the official cost below $1 trillion, when it’s really far higher.” Peter Orszag, then director of the Office of Management and Budget, defended CBO’s omission by arguing that “[a]n SGR fix, however, is not in this bill—so adding its costs to the legislation posits a piece of legislation that doesn’t exist.” Notwithstanding Director Orszag’s comments, a provisional, six-month Doc Fix was passed on June 24, 2010 by a vote of 417-1, along with some additional spending cuts. If permanent Doc Fix provisions had been included in the final ACA, as they were in the original House version, CBO would have reported large deficit increases. For Congress to continue its usual charade, then, artificially depresses medical spending projections.

The ACA will also require implementation spending which Congress omitted from the statute itself, possibly to prevent CBO from including it in budget estimates. According to former CBO Director Douglas Holtz-Eakin, the ACA ignores $114 billion in discretionary spending, all mandated by the ACA but not technically included within the statute. “[T]he budget office,” he wrote, “is required to take written legislation at face value and not second-guess the plausibility of what it is handed. So fantasy in, fantasy out.” Holtz-Eakin also agreed that the Doc Fix ought to have been included in the ACA and nothing fiscally responsible about pretending that Medicare will save money, from cuts that Congress has no intention to let go into effect, in order to make it seem like Medicare will spend less than it really will.”


259. Tully, supra note 252.

260. Id.


264. Holtz-Eakin, supra note 263.

265. Id.
ADVERSE REACTIONS

estimated overall that the ACA will actually increase deficits by $562 billion—a projection very similar to Fortune’s estimate of $488 billion. Additionally, there are serious concerns that CBO underestimated the cost of subsidies. A pro-ACA report by The Lewin Group calculated that over six years, subsidies might cost as much as $166 billion more than estimated by CBO. Even these pessimistic estimates assume that Congress stands by other revenue-raising provisions, such as the mandate and the Cadillac tax, which might prove politically unpopular or even unconstitutional. Even certain revenue-raising provisions, like the increase in net investment income taxes, could theoretically undermine revenue by deterring certain forms of taxpayer behavior.

CBO largely agreed with the complaints raised by Fortune Magazine and Holtz-Eakin, but its hands were tied. CBO’s report itself—the very same report that officially projects a deficit reduction—specifically highlights the Doc Fix as a “key consideration.” Director Elmendorf points out that the SGR “has frequently been modified . . . to avoid reductions in those payments, and legislation to do so again is currently under consideration by the Congress.” Moreover, just seven weeks after the ACA’s passage, CBO revised its estimates to include the legislation’s additional “authorized” costs and other considerations, raising the total cost by $115 billion over ten years. Director Elmendorf also expressed deep skepticism about several of the bill’s other deficit reduction provisions, which “would maintain and put into effect a number of policies that might be difficult to sustain over a long time.” CBO pointed out specifically

266. Id.
267. See Tully, supra note 252.
268. The Lewin Group estimates that subsidies may cost as much as $110 billion a year, which would extrapolate to $660 billion for 2014-2019. That compares disfavorably to CBO’s projection of $494 billion. See Families USA, Lower Premiums: The New Health Insurance Tax Credit 1 (2009), available at http://www.familiesusa.org/assets/pdfs/health-reform/Premium-Tax-Credits.pdf. Families USA, which sponsored the Lewin Group’s work, apparently considers this additional spending to be a positive feature of the ACA because the money would go toward families. Id.
269. See Editorial, Wash. Post, supra note 70.
271. See supra note 74 and accompanying text.
273. Id.
that it is unreasonable to expect provider reimbursements to drop over time in real terms, and that savings credited to as-yet-unknown ideas from the not-yet-constituted Independent Payment Advisory Board may never actually materialize. But CBO was instructed to score the bill as given, no matter how unrealistic, and it did so despite raising several objections of its own.

The ACA could, in theory, find other offsetting cost reductions, particularly if its preventive care measures prove more effective than expected by CBO and other experts. Still, over a longer period of time, perhaps some of the pilot programs in the legislation will prove effective. Dr. Atul Gawande suggests that there is reason for hope: Despite the absence of any overall plan to reduce costs, the statute does introduce several pilot programs—"a test of almost every approach that leading health-care experts have suggested." Nonetheless, these pilot programs remain uncertain: They may not work or, more troubling, they might work but not be implemented.

These pilots could yield savings, but CBO is rightly skeptical. On balance, preventive care measures tend to increase rather than decrease expenditures. While CBO argues that some of these savings could reduce long-term deficits, with its best estimate being "a broad range between one-quarter percent and one-half percent" of gross domestic product (GDP), it notes that "[t]he imprecision of that calculation reflects the even greater degree of uncertainty that attends to it." And, of course, this is "relative to those [deficits] projected

276. Id.

277. Id.

278. Much of the statute is devoted to preventive care measures; unfortunately this Note does not have the space to explore them. See, e.g., PPACA, Pub. L. No. 111-148, §§ 4001-402, 124 Stat. 119, 538-88 (2010). CBO appears to give very little weight to these efforts over the course of a ten-year horizon. See Letter from Cong. Budget Office to Nancy Pelosi, supra note 13.


280. See Jack Hadley & John Holahan, Covering the Uninsured: How Much Would it Cost?, Health Aff., June 4, 2003, at W3-250, W3-250, available at http://content.healthaffairs.org/content/early/2003/06/04/hlthaff.w3.250.full.pdf ("[T]he uninsured would use $33.9-$68.7 billion (in 2001 dollars) in additional medical care if they were fully insured."). This is, of course, an astonishingly low cost; but for the purposes of tracking expenditures, health insurance is not cost-reducing.

under current law”—that is, it still includes the additional imaginary health expenditure savings associated with Medicare cuts. The analysis assumes, CBO notes dryly, “that all of its provisions continued to be fully implemented.”

The ACA almost certainly will not decrease short-term deficits and may have troubling long-term effects as well. In fact, it appears likely to increase deficits by nearly half a trillion dollars over the next ten years.

Conclusion

The ACA outlaws certain types of insurance industry actions and thus officially enforces a set of social norms regarding patients’ entitlements. The legislation protects the unhealthy from insurance discrimination and, in so doing, shifts our insurance system from an actuarially-based model towards a social conception of solidarity. In fact, with passage imminent on March 20, the President described the ACA as a “patient’s bill of rights on steroids.” If the plan functions as designed, that description will be vaguely accurate: The package does not just protect policyholders, but also anybody who wishes to become a policyholder.

Of course, the steroids metaphor was not meant to be taken literally. But perhaps it should be. Anabolic steroids provide a temporary benefit at the cost of the body’s long-term health. There are parallels in the ACA. The prohibition against health status discrimination provides protection to patients, but it does so while exacerbating a number of economic problems. The ACA necessarily implements several policy solutions to address these issues, but each solution creates another problem. The ACA’s nondiscrimination requirement motivates the healthy to leave insurance pools, and, if they desert en masse, the insurance market will not be able to support its own weight. The legislation thus imposes an insurance mandate to keep the healthy in the insurance pool, but its relatively low mandate will likely prove inadequate to the task. The legislation provides subsidies and a hardship exemption to make the mandate affordable, but the hardship exemption exacerbates adverse selection while the subsidies require revenue. The legislation raises revenue to pay for those subsidies but will probably nonetheless dramatically raise deficits.

For all its flaws, the ACA represents a single, well-intentioned goal: securing health insurance for a wider segment of society, regardless of health status. But

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283. Id.
285. See generally Gen Kanayama et al., Long-Term Psychiatric and Medical Consequences of Anabolic-Androgenic Steroid Abuse, 98 DRUG & ALCOHOL DEPENDENCE 1, 1 (2008).
the ACA attempts to do this by making the private health insurance market into something that it is not. To ban discrimination based on preexisting conditions is to change insurance from a device for risk-distribution into a tool for expense-distribution. The Affordable Care Act, no matter how well-intentioned, is unable to address the market failures that will necessarily result.