

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

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ABSTRACT

On March 24th, 2010, President Obama signed the Patient Protection and Affordable Care Act, declaring, “everybody should have some basic security when it comes to their health care.” This Note provides a comprehensive examination of this complex legislation. Second, it reframes the bill by proposing that its miscellaneous-seeming provisions are designed to protect a single, central provision: the ban on health discrimination. Finally, it argues that underlying economic forces will likely cause PPACA to do more harm than good. While health reform may ultimately prove successful, America has good reason to be concerned.

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INTRODUCTION

On March 24th, 2010, President Barack Obama signed into law H.R. 3590,¹ the Patient Protection and Affordable Care Act (PPACA), declaring that “everybody should have some basic security when it comes to their health care.”² Lauded as “the most expansive social legislation enacted in decades,”³ PPACA, and its companion bill, the Health Care and Education Reconciliation Act of 2010 (HCERA)⁴ are tremendously lengthy and complex bills⁵ aimed at accomplishing a variety of social purposes. In a September 2009 address before Congress, President Obama argued that health care had become unaffordably costly⁶ and that too many Americans were uninsured.⁷ Most vivid in the President’s speech, however, was 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

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) [hereinafter PPACA].

2. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Into Law*, N.Y. TIMES, Mar. 23, 2010, at A1.

3. *Id.*

4. Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (signed by President Obama on March 30, 2010) [hereinafter HCERA]. See William Branigin, *Obama Signs Higher-Education Measure into Law*, WASH. POST, Mar. 30, 2010, <http://voices.washingtonpost.com/44/2010/03/obama-signs-higher-education-m.html>.

5. PPACA itself totals 2409 pages. See PPACA. HCERA is an additional 153 pages, for a total of 2562. See HCERA.

6. 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 (last visited Apr. 12, 2010).

7. *Id.*

America.⁸

The above examples were meant to illustrate the President's main point of contention: that the insurance industry currently discriminates against the sick and the unhealthy—using even trivial matters to deny coverage.⁹ This is not a new complaint,¹⁰ and 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.”¹¹

The President further argued that the reform proposal—the proposal that would eventually evolve into the PPACA—could solve these problems, saying:

Now is the time to deliver on health care. The plan I'm announcing tonight would meet three basic goals. It will provide more security and stability to those who have health insurance. It will provide insurance for those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government.¹²

For its part, the Congressional Budget Office (CBO) largely agreed with President Obama's predictions. It estimated that PPACA would reduce federal deficits by \$143 billion from 2010-2019, of which \$124 billion would be directly related to health reform.¹³ CBO also estimated that the bill would help reduce the ranks of the nonelderly uninsured by 32 million, from about 17% to about 6%.¹⁴ At a first glance, it seems that PPACA is well on its way to accomplishing its goals.

This Note proceeds to analyze the bill in three Parts, with each Part

8. *Id.*

9. *Id.*

10. See, e.g., Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73 (2005).

11. See Obama, *supra* note 6.

12. *Id.*

13. Congressional Budget Office (CBO), Letter to the Honorable Nancy Pelosi Providing an Analysis of the Reconciliation Proposal, (Mar. 20, 2010), available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf> (last visited Apr. 12, 2010) (the remainder of the reduction came from the bill's changes to student loans and CBO's projected changes to Social Security, the Postal Service, and other elements).

14. *Id.*

contributing to the literature in a specific way. PPACA and HCERA are tremendously detailed pieces of legislation and have been the subjects of extraordinary confusion. Legal scholarship will play a role in definitively dispelling many of the myths that have arisen around this landmark legislation, and Part I of this Note serves to provide a broad review of these highly complex statutes. This lays a foundation for analysis, but is also a crucial contribution in its own right.

In order to evaluate the reform bill, we must next define its intentions. In Part II, I propose a conceptual understanding of PPACA's design: specifically, I argue that the central provision of the bill is the ban on health status discrimination. Each of the other major components of the bill—the mandate, the subsidy, and the revenue provisions—is designed to ameliorate the market interference of this core regulation. This Note examines each component of the health reform bill accompanied by a review of the underlying legal and health policy scholarship—and thus aims to lay a foundation for future analysis.

Finally, Part III assembles the available evidence to argue that PPACA, despite its admirable intentions, is unlikely to accomplish its goals. PPACA has been subject to wide-ranging criticism, but this Note systematically organizes economic projections, including CBO's, to demonstrate that the underlying math simply will not yield to legislative intentions. It appears that the bill probably will not eliminate insurer discrimination; may exacerbate rather than alleviate medical deprivation; and will almost certainly not result in reduced federal deficits. Most frighteningly, Part III.B examines the bill's methods for preventing the unraveling of health insurance—and concludes that they are almost certainly inadequate because the costs of health insurance are likely to rise dramatically. PPACA, if it proceeds as expected, will almost certainly be a self-defeating piece of legislation.

This pessimism is not by any means set in stone, as the federal government still has many decisions remaining. The insurance industry's choices will also matter, and so will the choices of millions of ordinary Americans. Health reform may ultimately prove successful—but, for now, the nation has good reason to be highly concerned.

I. FOUR COMPONENTS

A. *Insurance Regulation*

President Obama's address to Congress highlighted a series of egregious industry behaviors with a particular focus on rescission—the practice of withdrawing a policyholder's insurance coverage, sometimes for seemingly trivial reasons. And rescission is not a particularly rare practice: a House Energy and Commerce Committee investigation found that just three insurance companies had rescinded 19,776 policies over five years, saving themselves \$300 million.¹⁵ The President's address demanded that such behavior be outlawed, and, accordingly, the bill itself commences with several prohibitions on insurer discrimination against the unhealthy.

First, PPACA imposes guaranteed issue, stating: “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.”¹⁶ All applicants, even those with preexisting illnesses, must be accepted.

As a logical extension of guaranteed issue, PPACA prohibits rescission.¹⁷ Unless policyholders commit actual fraud, the bill demands that insurers grant continuing coverage and a guarantee of renewability.¹⁸ Congress specifically prohibits discrimination based on “health status-related factors,” and it proceeds to define this term in every conceivable way: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, and any other health status-related factor, as determined by the Secretary for Health and Human Services (HHS).¹⁹

These regulations, of course, would be useless without accompanying rate regulation—otherwise, insurers could simply price ill individuals out of the market. The plan thus prohibits rate discrimination based on health

15. Joanne Silberner, Insurers Revoke Policies to Avoid Paying High Costs, NPR, June 22, 2009, *available at* <http://www.npr.org/templates/story/story.php?storyId=105680875> (last visited Apr. 12, 2010).

16. PPACA, Pub. L. No. 111-148, § 1201 (2010).

17. *Id.* § 1001.

18. *Id.* § 1201.

19. *Id.*

status.²⁰ 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.²¹ The obvious omission is health status, and this is crucial enough that PPACA repeats itself almost immediately: “such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described” above.²² Additionally, there is to be no discrimination based on gender or salary.²³

This new regulations already represent a landmark change in the way that health insurance currently operates—and even these four permitted categories come with additional restrictions.

First, insurance plans are permitted only to regard the binary status of individual or family—they may not charge different rates based on the *size* of a family.

Second, geographic units are at the discretion of the states (subject to veto by HHS),²⁴ and geographic discrimination could ultimately be limited to state-by-state rates.²⁵ 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. Any state which governs either too tightly or too loosely is subject to being overruled by HHS.

Third, age discrimination is permitted, but only up to a 3:1 ratio. Current national ratios are 4.26:1 when comparing an eighteen year old to a sixty-four year old,²⁶ and so PPACA appears to mandate at least a 42% increase in relative premiums for young policyholders—a non-trivial increase. And this is already an underestimate, since the 4.26:1 ratio does not include anybody over 64 years old. Age brackets are pending final

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.* § 2716.

24. *Id.*

25. *Id.*

26. See America’s Health Insurance Plans, Individual Health Insurance 5, Oct. 2009, available <http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf> (last visited Apr. 12, 2010) (indicating that the average annual premium was \$1,350 for an individual policyholder under 18, but \$5,755 for somebody 60-64).

HHS approval, but tentatively the truly elderly do appear to be included.²⁷

Fourth, smokers can be charged higher rates, with a maximum differential of 1.5 to 1. This is not a general “unhealthy behavior premium”—it applies specifically to tobacco use.²⁸ It says nothing about other substance abuse, risky sexual practices, unhealthy eating or exercise habits, or medication compliance. And a smoker—even one with a history of cardiac arrest or lung cancer—may be charged no more than 150% of the premium imposed on his non-smoking, healthy counterpart.

The bill also includes a variety of other insurance reforms. To highlight just a few, insurance plans must: cover preventive care;²⁹ cover dependents until age twenty-six;³⁰ have no annual or lifetime coverage limits;³¹ and cap out-of-pocket spending at \$2,250 (adjusted for inflation).³² Insurers must spend at least 80% of revenue from premiums on incurred claims losses.³³ Even this list is not all-inclusive.³⁴

The core element of the bill, however, remains the non-discrimination regulation. In short, insurers’ ability to screen their patients—to “cherry-pick”³⁵—has been dramatically curtailed. This is, of course, precisely the goal of the PPACA,³⁶ and the importance of this regulation cannot be overstated. Each of PPACA’s other components is a natural extension of this one.

27. PPACA § 1201.

28. At least one Internet commentator had worried that the bill provided a general “unhealthy behavior premium,” which insurance companies could exploit. See mcjoan, *How Insurers Can Game the New System*, DAILY KOS, Apr. 1, 2010, available at <http://www.dailykos.com/storyonly/2010/4/1/853166/-How-Insurers-Can-Game-the-New-System> (last visited Apr. 12, 2010). This particular argument is incorrect, see PPACA § 1201, and most of the article’s other concerns are not new complaints.

29. PPACA § 1001.

30. *Id.*

31. *Id.*, modified by § 10101(a).

32. PPACA § 1302(c)(1); I.R.C. § 223(c)(2)(A)(ii). The limit is \$4,500 for a family insurance plan. I.R.C. §§ 223(c)(2)(B)(ii).

33. HCERA, Pub. L. 111-152, § 10101(f) (2010). The required “medical loss ratio” is 85% in the large group market. *Id.*

34. Additional requirements for a minimum plan appear in PPACA § 1302(b)(1). See *infra* text accompanying note 43 (describing qualifying minimum plans) and note 46 (describing requirement that all plans be “comprehensive”).

35. See Obama, *supra* note 6.

36. *Id.*

B. The Mandate

Additionally, PPACA requires all individuals to either possess an insurance policy or pay a fine³⁷ in the form of a new tax which will be waived if the taxpayer can prove that he or she is insured.

The tax scales up over time, reaching its peak in 2015 and thereafter. At that time, 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.³⁸ This is generally greater than the fine in the original Senate bill, which would have been \$750.³⁹ PPACA's actual fine would be \$2,500, for example, for an individual making \$109,350 a year, or for a family making \$118,700 a year. The fine would be paid as part of a tax return,⁴⁰ and is codified as part of the Internal Revenue Code.⁴¹ It will depend on the IRS for implementation and enforcement.

The mandate levies that fine against any individual who is not "covered under minimum essential coverage" for any single month.⁴² "Minimum essential coverage," however, is not defined by PPACA itself—instead, Congress delegates that authority to HHS.⁴³ The statute does impose substantial requirements as components of any minimum plan: it 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—even for patients who could not conceivably use such services.⁴⁴ Additionally, several general insurance regulations will also serve *de facto* as part of the floor.⁴⁵ Nonetheless, HHS will retain

37. PPACA § 1501, *modified by* § 10106; *amended by* HCERA § 1002.

38. PPACA § 1501, *modified by* § 10106; *amended by* HCERA § 1002. The minimum amount seems to be \$2,000. *See* I.R.C. § 6012(a)(1) and § 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, respectively, adjusted for inflation since 1989). *See* Internal Revenue Service, 1040 Instructions 2009, 8, chart A, <http://www.irs.gov/pub/irs-pdf/i1040.pdf> (listing updated threshold amounts).

39. PPACA § 1501(c), *modified by* § 10106; *amended by* HCERA § 1002.

40. PPACA § 1501(b)(2).

41. *Id.* § 1501(b).

42. *Id.* § 1501(a).

43. *Id.* § 1302(b).

44. *Id.* § 1302(b)(1). All plans, for example, must cover maternity care, with no exception for male policyholders. *Id.*

45. *See supra* text accompanying notes 29-33.

considerable room to operate. It will not be allowed to determine premiums—although it will have authority to review future rate increases⁴⁶—but it will nonetheless have the authority to declare that all plans must meet certain minimum standards.⁴⁷

Importantly, the mandate fine 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.⁴⁸ (It also contains a religious exemption.)⁴⁹ Depending on how the insurance market reacts—and exactly what the mandate includes⁵⁰—this hardship exemption could potentially 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.⁵¹ The language of the bill appears to presume, probably correctly,⁵² that the 8% hardship exemption can be raised, but never lowered.

Among other provisions, the individual mandate has been challenged on constitutional grounds.⁵³ The constitutional merits of these lawsuits are beyond the scope of this paper, but Congressional findings—inserted precisely into this section,⁵⁴ perhaps anticipating challenges—appear to

46. PPACA § 1003.

47. *Id.* § 1302(b). *See also id.* § 1201 (requiring all health insurers to provide comprehensive coverage, effectively outlawing any new issuances of a “catastrophic” plan except in specific situations); *id.* at § 10902 (limiting payments to health flexible spending arrangements). The bill 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 to the individual market for those who are under 30 or for whom the hardship exemption (see *infra* text accompanying note 48) applies. *Id.* § 1302(e).

48. *Id.* § 1501(b).

49. *Id.*, referencing § 1311(d)(4)(H).

50. *See infra* Part III.B.

51. PPACA § 1501(b).

52. *See* Christopher J. Truffer et al., *Health Spending Projections Through 2019: The Recession's Impact Continues*, 29 HEALTH AFF. 522, 526 (2010) (explaining that health spending is likely to continue rising faster than income).

53. Complaint, State of Florida vs. United States Department of Health and Human Services (N.D.Fl. 2010) (No. 3:10 Civ. 91), *available at* [http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/\\$file/HealthCareReformLawsuit.pdf](http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/$file/HealthCareReformLawsuit.pdf).

54. *See* PPACA § 1501(a) (declaring that the bill is constitutional under Commerce Clause authority).

place the statute firmly within Congress’s Article I authority.⁵⁵

In addition to the individual mandate, Congress also imposed incentives for 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.⁵⁶ That is, a firm which employs 130 employees must pay \$200,000—provided that any one of these employees receive a subsidy, as described below.⁵⁷ 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.⁵⁸ Presumably, the higher fee is designed to penalize employers who provide coverage for some, but not all, employees. Congress also imposed voucher requirements for employers⁵⁹ and substantial tax incentives for small businesses⁶⁰—but at its core, the mandate is simple: individuals, whether healthy or sick, are required to have health insurance. If their employers do not provide it, then they must do so themselves.

C. Subsidies

The bill also provides two kinds of subsidies: one to assist in the

55. See U.S. CONST. art I., § 8 (“The Congress shall have Power . . . to regulate commerce . . . among the several States”). See also Timothy Stoltzfus Jost, Health Bill Lawsuits Are Going Nowhere, CNN.COM, Mar. 24, 2010, available at <http://www.cnn.com/2010/OPINION/03/24/jost.health.bill.challenges/index.html>; Jack Balkin, A Tax Like Any Other, N.Y. Times, Mar. 28, 2010, available at <http://roomfordebate.blogs.nytimes.com/2010/03/28/is-the-health-care-law-unconstitutional> (last visited Apr. 13, 2010) (“The individual mandate . . . is a tax on behavior, like a tax on businesses that don’t install anti-pollution equipment.”); 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) (characterizing the mandate as a tax).

56. PPACA § 1513(a), amended by HCERA, Pub. L. 111-152, § 1003(b)(2) (2010).

57. See *infra* Part I.C. Presumably, any business at which no employee has a low enough income to qualify for the subsidy would not pay any fines. PPACA § 1513(a), amended by HCERA § 1003(b)(2) (2010).

58. PPACA § 1513(c), amended by HCERA § 1003(b)(1).

59. 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.* at § 10108. These vouchers would be usable in an Exchange, for which details can be found in Part I(D), *infra*.

60. PPACA § 1421, modified by § 10105(e).

payment of insurance premiums, and one to assist in cost-sharing.

First, federal tax credits provide premium assistance for families which fall beneath certain income thresholds and which do not receive employer-provided insurance.⁶¹ The bill 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),⁶² such that taxpayers would pay no more than the following for the applicable second-lowest-cost “silver” plan:⁶³

Table 1: Premium Subsidy⁶⁴

Income	Maximum Premium Contribution
Up to 133% of FPL	2% of income
133-150% FPL	3-4% of income
150-200% FPL	4-6.3% of income
200-250% FPL	6.3-8.05% of income
250-300% FPL	8.05-9.5% of income
300-400% FPL	9.5% of income

In other words, the subsidy is not a flat fee; it is properly understood as an effective cap on health insurance premiums. It functions on a linear sliding scale,⁶⁵ except that it appears to cut off suddenly after 400% FPL;⁶⁶ perhaps Congress believed that the price of health insurance would be less than these caps anyway, alleviating the transition. The subsidy is scheduled to be adjusted based on premium growth over and above general income growth,⁶⁷ with additional adjustments in the event of particularly large increases in government expenditures on PPACA and HCERA subsidies.

Second, the bill also provides subsidies meant to reduce “cost-sharing” provisions such as deductibles and co-pays. The government will

61. *Id.* § 1401.

62. The Federal Poverty Line is determined by the Office of Management and Budget based on U.S. Census data, and modified by HHS. 42 U.S.C. 9902(2).

63. The “silver” plan is a plan that gets included at the second tier in State exchanges. *See infra* Part I.E.

64. HCERA, Pub. L. 111-152, § 1001(a)(1)(A) (2010).

65. *Id.*

66. *Id.*

67. *Id.* § 1001(a)(1)(B)(I).

refund credits equivalent to the following amounts of incurred cost-sharing:

Table 2: Cost-Sharing Subsidy⁶⁸

Income	Cost-Sharing Reduction
100-150% FPL ⁶⁹	94%
150-200% FPL	87%
200-250% FPL	73%
250-400% FPL	70%

In 2010, the Federal Poverty Line was set at \$10,830 for an individual, or \$22,050 for a family of four.⁷⁰ Subsidies are provided, therefore, until an individual makes \$43,320 and until a family of four has income of \$88,200.

D. Cost-Reducing and Revenue-Generating Provisions

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

First, PPACA contains several tax increases. Most obviously, the fines from the individual⁷¹ and employer mandates⁷² will generate some revenue. The bill also imposes a 40% excise tax—often referred to as the “Cadillac tax”⁷³—on the value of any employer-sponsored insurance plan

68. *Id.* § 1001(b).

69. Those beneath 100% FPL are Medicaid-eligible. *See infra* text accompanying note 128.

70. 74 Fed. Reg. 4199-4201 (Jan. 23, 2009) (setting FPL thresholds as described). HHS’s usual adherence to inflation measures would have lowered the 2010 levels. *See* U.S. Department of Health and Human Services, Extension of 2009 Poverty Guidelines Until at Least March 31, 2010, *available at* <http://aspe.hhs.gov/poverty/09extension.shtml>. Accordingly, Congress took action to keep the 2009 FPL guidelines in place. *See* Pub. L. 111-118 (“the Secretary of Health and Human Services shall not publish updated poverty guidelines for 2010”).

71. PPACA, Pub. L. No. 111-148, § 1501 (2010), *modified by* § 10106; *amended by* HCERA, Pub. L. 111-152, § 1002 (2010).

72. PPACA § 1513(a), *amended by* HCERA § 1003(b)(2); *id.* § 1513(c), *amended by* HCERA § 1003(b)(1).

73. Editorial, *Will President Obama Defend the Cadillac Tax to Cut Health-Care*

that exceeds annual values of \$10,200 for an individual or \$27,500 for a family, as adjusted for 2018⁷⁴ based on the increase in the costs of health insurance for the Federal Employees Health Benefits Plan (commonly known as FEHBP).⁷⁵ Thereafter, adjustments will be based on general consumer inflation plus 1%.⁷⁶ The bill also imposes additional income taxes: filers who make over \$200,000 (\$250,000 for a married couple) will face an additional 0.9% payroll tax over that threshold.⁷⁷ They will also face a new 3.8% surtax on net investment income or adjusted gross income over the threshold, whichever is less.⁷⁸

The bill also imposes a variety of new industry taxes: \$27 billion over ten years in pharmaceutical industry fees,⁷⁹ 2.3% excise taxes on medical devices,⁸⁰ 10% service taxes on indoor tanning;⁸¹ \$2-per-enrollee fees for insurers,⁸² and \$60.1 billion over ten years in insurance industry fees.⁸³ Finally, the bill increases the rebates associated with the Medicaid Rebate Program,⁸⁴ a program in which pharmaceutical manufacturers must “rebate” certain percentages of their sales in exchange for their products being eligible for Medicaid coverage.⁸⁵

Second, the bill 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,⁸⁶ which compensates any

Costs?, WASH. POST, Jan. 12, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/01/11/AR2010011103585.html>.

74. PPACA § 9001, *amended by* HCERA § 1401.

75. HCERA § 1401(a)(2)(C).

76. PPACA § 9001, *amended by* HCERA § 1401(a)(2)(E).

77. PPACA § 9015(a)(1), *modified by* § 10906, *amended by* HCERA § 1402(b)(2).

78. HCERA. § 1402(a).

79. PPACA § 9008, *amended by* HCERA § 1404.

80. HCERA § 1405. The Senate Bill’s original tax was repealed and replaced entirely by HCERA. *See* PPACA at § 9009, *modified by* § 10904, *repealed by* HCERA § 1405(d).

81. PPACA § 10907 (nullifying § 9017, a tax on cosmetic medical procedures).

82. *Id.* § 6301(e)(2)(A).

83. PPACA § 9010, *modified by* § 10905, *amended by* HCERA at § 1406(a)(4).

84. *See* PPACA §§ 2501-2502.

85. *See* Congressional Budget Office, *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry*, Jan. 1996, <http://www.cbo.gov/doc.cfm?index=4750&type=0>.

86. PPACA § 2551.

hospital which has a “disproportionate share” of non-paying patients.⁸⁷ It completely eliminates the “Medicare Improvement Fund,”⁸⁸ a fund through which HHS could have made unspecified improvements to Medicare in the years 2014 and 2015.⁸⁹ It reduces payments to Medicare Advantage,⁹⁰ a subset of Medicare in which plans can be administered by private insurers.⁹¹ Most dramatically, PPACA 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.⁹²

Third and finally, the bill establishes a variety of measures designed to reduce federal government medical expenses over the long-term. Chiefly, they can be organized into anti-corruption, pay-for-performance and pilot programs, and an independent advisory board.

Its anti-corruption provisions include, among other programs: expanding the definition of “federal health care offense” and increasing associated sentences;⁹³ eliminating new instances of the whole-hospital exception in prohibitions on physician hospital ownership;⁹⁴ mandating disclosure of physician payments from or ownership in drug and device manufacturers;⁹⁵ and increased funding for the Health Care Fraud Abuse

87. See Department of Health and Human Services, Disproportionate Share Hospital, <http://www.hhs.gov/recovery/cms/dsh.html> (last visited Apr. 16, 2010) (describing the impact of the American Recovery and Reinvestment Act of 2009 on DSH funding).

88. PPACA § 3112.

89. 42 U.S.C. § 1395iii (2009).

90. See, e.g., PPACA § 3201(b) (specifying a spending freeze for 2011); § 3201(d)(2) (codifying a more competitive, actuarially-based bidding process).

91. Medicare.gov, Medicare Advantage Plans, <http://www.medicare.gov/choices/advantage.asp> (last visited Apr. 16, 2010) (detailing various options associated with Medicare Advantage); AARP Health, Medicare Advantage Transition, <http://www.aarphealthcare.com/products/medicareadvantage/> (last visited Apr. 16, 2010) (explaining that Medicare Advantage is privately administered).

92. See PPACA § 3401.

93. *Id.* § 10606.

94. PPACA § 6001, *modified by* § 10601, *amended by* HCERA, Pub. L. 111-152, § 1106 (2010). The so-called “Stark Law” 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).

95. PPACA § 6002.

and Control Fund.⁹⁶

The bill includes a loose sort of “pay for performance” scheme for hospitals, in which Medicare hospital payments are reduced slightly to fund incentive payments for high-performance.⁹⁷ “High-performance” is left to HHS’s discretion, but must include efficiency measures, “including measures of ‘Medicare spending per beneficiary.’”⁹⁸ It also reduces payments to hospitals which have “excess readmissions”⁹⁹—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.¹⁰⁰ Additionally, certain groups of providers, including physicians and hospitals, will be permitted to function as “Accountable Care Organizations,” which will share some of the savings from cost reduction—provided that quality does not fall.¹⁰¹

PPACA also includes a variety of pilot programs and experiments aimed at reducing costs. For example, it authorizes HHS to begin pilot programs for payment bundling¹⁰² and pay-for-performance.¹⁰³ In the case of payment bundling, HHS is authorized to expand the pilot so long as quality of care does not suffer.¹⁰⁴ Additionally, HHS is authorized to award five-year “demonstration grants” to states to develop “alternatives to current tort litigation” relating to health care.¹⁰⁵ Presumably, successful programs would be presented to Congress for wider consideration.

Fourth and finally, PPACA authorizes the creation of an Independent Payment Advisory Board (IPAB) comprised of fifteen voting members appointed by the President to have “a mix of different professionals” including health economics experts, physicians, and others.¹⁰⁶ The IPAB,

96. *Id.* § 6402(i).

97. *Id.* § 3001.

98. *Id.* § 3001(a).

99. *Id.* § 3025.

100. *Id.* § 2702. 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) (2006).

101. PPACA §§ 2706, 3022, 3129.

102. *Id.* § 3023, *modified by* § 10308.

103. *Id.* § 10326.

104. *Id.* § 10308(a)(2).

105. *Id.* § 10607.

106. *Id.* § 3403 (referred to as Independent Medicare Advisory Board), *modified by* § 10320 (designating a name change).

intended to “reduce the per capita rate of growth in Medicare spending,”¹⁰⁷ would develop “detailed and specific proposals” and submit those proposals to MedPAC, HHS, the President, and Congress.¹⁰⁸ These proposals “shall not include any recommendation to ration health care, raise revenues . . . or otherwise restrict benefits of modify eligibility criteria.”¹⁰⁹ Certain IPAB recommendations—especially those relating to Medicare Advantage and Part D plans—would be automatically implemented by HHS unless Congress could fast-track an equivalent savings plan.¹¹⁰

E. Other Provisions

In addition to the four components mentioned above, PPACA also contains several provisions aimed at improving access to health insurance and to medical care more generally.

Most famously, it requires each state to establish an “American Health Benefit Exchange,”¹¹¹ or to participate in a multi-state Exchange.¹¹² Exchanges would ideally perform a valuable informational function for consumers, acting as a database and streamlined resource where consumers could research and purchase insurance plans. These exchanges will start in 2014 covering individual and small employer markets; in 2017, states may opt to include large group employers as well. Each plan in an Exchange must meet federally-mandated minimum benefit standards.¹¹³ These standards have yet to be determined and remain at the discretion of HHS, although several specific components are specified.¹¹⁴ While states are permitted to set higher standards, they must pay the premium difference to any individual who receives federal subsidies.¹¹⁵

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.*

109. *Id.*

110. *Id.*

111. *Id.* § 1311(a).

112. *Id.* § 1311(f). 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(d)(2)(B)(i) (“An Exchange may not make available any health plan that is not a qualified health plan.”).

114. *See supra* text accompanying notes 29-33. PPACA repeats the requirement for mental health parity in § 1311(j).

115. PPACA § 1311(d)(3)(B).

Exchange plans are to be sorted according to “actuarial value,” the percentage of projected medical expenses which is covered by a given plan.¹¹⁶ A “Bronze” plan has an actuarial value of 60%, and each additional tier increases that percentage: Silver (70%), Gold (80%), and Platinum (90%).¹¹⁷ HHS would “rate” each plan “on the basis of relative quality and price,”¹¹⁸ and would post its rating online, accompanied by enrollee satisfaction data.¹¹⁹ Exchanges must demand justification for any premium increases from insurers who seek Exchange certification,¹²⁰ but they are not permitted to exclude a plan from the Exchange by using premium price controls¹²¹ and are expressly prohibited from rationing life-saving medical treatments.¹²² Exchanges will have a standard format for displaying health benefits plan options,¹²³ calculators to incorporate any federal subsidies,¹²⁴ and other tools.¹²⁵ Exchanges will also serve as the reporting medium for indicating, among other things, individuals whose employers did not provide insurance, thus subjecting those employers to a penalty.¹²⁶

In addition to Exchanges, PPACA provides several other provisions designed to improve access to care. While it has no government-financed insurance plan (a “public option”¹²⁷), it provides for the government to

116. California HealthCare Foundation, Actuarial Value: A Method for Comparing Health Plan Benefits, <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=133789> (last visited Apr. 17, 2010).

117. PPACA § 1302(d).

118. *Id.* § 1311(c)(3).

119. *Id.* §§ 1311(c)(3)-(5). § 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).

120. *Id.* § 1311(e)(2).

121. *Id.* § 1311(e)(1)(B)(ii).

122. *Id.* § 1311(e)(1)(B)(iii).

123. *Id.* § 1311(d)(4)(E).

124. *Id.* § 1311(d)(4)(G).

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).

126. *Id.* § 1311(d)(4)(I)(ii).

127. For use of the term, see Sheryl Gay Stolberg, *'Public Option' in Health Plan May Be Dropped*, N.Y. TIMES, Aug. 17, 2009, at A1, available at <http://www.nytimes.com/2009/08/18/health/policy/18talkshows.html> (last visited Apr. 17, 2010).

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.¹²⁸

More directly, the law also expands existing programs. First, it requires that states extend Medicaid to all non-elderly individuals up to 133% of FPL—removing all previous non-income qualifications.¹²⁹ The simplicity of this change almost disguises its importance, but it is obviously valuable for the applicable population. Second, it provides 23% in additional federal funding for the Children’s Health Insurance Program (CHIP) from the years 2016-2019.¹³⁰ Third, over the next ten years HCERA closes a gap in Medicare prescription drug coverage—the famous “donut hole”¹³¹—by lowering beneficiary coinsurance in that range from 100% to 25%.¹³²

Finally, the bill attempts to increase access to medical care independent of insurance status. It allocates an expansion investment fund¹³³ and general funding¹³⁴ for Community Health Centers (CHCs), defined previously by the Public Health Service Act¹³⁵ as being designed to reach medically underserved populations, with particular emphasis on migrant workers, the homeless, and residents of public housing.¹³⁶ CHCs 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.¹³⁷ PPACA 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.”¹³⁸

Regrettably, this Note can provide only a partial summary of PPACA’s provisions. PPACA also effects changes in the health care

128. PPACA § 10104, *adding* § 1334.

129. *Id.* § 2001

130. *Id.* § 2101, *amended by* § 10203(c)(2)(a)(i).

131. See Duff Wilson, *Filling the Donut Hole*, N.Y. TIMES, Mar. 20, 2010 at A10.

132. HCERA, Pub. L. 111-152, at § 1101(b) (2010) (“Closing the Medicare Prescription Drug Donut Hole”).

133. PPACA at § 10503.

134. Compare PPACA § 5601(a) with 42 U.S.C. § 254b(r).

135. 42 U.S.C. § 254b.

136. *Id.* § 254b

137. *Id.* § 254b(k)(3)(G)(i).

138. See PPACA § 9007, *modified by* § 10903.

workforce,¹³⁹ preventive care services,¹⁴⁰ and other areas. In addition, this Note deals with PPACA at its eventual, complete implementation, since detailing the bill's "transitional" provisions¹⁴¹ would require much more space. Nonetheless, the major provisions of the bill are represented here, and Part I serves as the crucial underpinning for an examination of the *design* of health reform.

II. THE ARCHITECTURE OF REFORM

"What ends do we expect health insurance to serve in our society?" asks Professor Mary Crossley.¹⁴² That question constitutes "the struggle for the soul of health insurance,"¹⁴³ and I argue that the answer—as given by the President and by Congress—necessarily dictates the entire structure of health reform. The philosophic core of the bill establishes the standards against which empirical effects must be measured. I propose here that the bill is designed with one chief objective: ensuring that all citizens, regardless of any preexisting conditions, have reliable access to stable health insurance. A close examination will demonstrate that each of the major provisions of health reform is designed to protect that singular goal.

A. *Solidarity Insurance and Community Rating*

In an unregulated market, insurance is fairly simple: companies permit risk-averse individuals to purchase plans that ameliorate that risk. In exchange, those individuals pay slightly more than they expect to gain, allowing the insurer to pay overhead costs and collect profits. Market insurance is not meant to help people buy things they could otherwise not afford; it is meant to make their finances *predictable*. It distributes *risk*, not *expense*.

Crucially, that risk must be distributed across a pool of policyholders which, *ex ante*,¹⁴⁴ appears identical. If some are predictably higher-risks,

139. *Id.* §§ 5001-5701.

140. *Id.* §§4001-4402.

141. For example, PPACA dictates that HHS will establish a temporary high-risk pool which would continue through 2013 and end promptly thereafter. *Id.* § 1101.

142. See Crossley, *supra* note 10, at 1.

143. *Id.*

144. For a discussion of *ex ante* versus *ex post* distinctions, see Uwe E. Reinhardt, Is 'Community Rating' in Health Insurance Fair?, N.Y. TIMES, Economix Blog, Jan. 1, 2010 (last visited Apr. 17, 2010).

then the low-risk population would break off to form a new pool in which they would pay lower premiums. Insurance pools thus tend to segregate, with high-risk patients consistently excluded from low-risk, lower-premium pools.

This is precisely how the insurance industry has historically operated. As Crossley explains, “[d]iscrimination against unhealthy persons is *deeply ingrained*” in health insurance, and is “generally accepted as a legitimate application of . . . risk-classification.”¹⁴⁵ When less-healthy patients find a good insurance deal *en masse*, the plan becomes unsustainable. Any single insurer which finds itself “stuck” with a high-risk pool will bleed money to pay the health care costs of the less-healthy patients. If it increases rates to cover costs, it will bleed even more money as healthy policyholders flee to other, lower-premium insurers, and the original insurer will promptly go bankrupt.

The President highlighted rescission as being a particularly horrifying practice,¹⁴⁶ but it is actually a fairly predictable economic result of market insurance: it is, simply put, low-risk people kicking high-risk people out of their pool to keep premiums low. Indeed, these stories are far from rare.¹⁴⁷ To President Obama and Democratic leaders in Congress, this segregation contradicts the very purpose of health insurance, which ought to follow what Professor Crossley describes as a “social solidarity” model, in which “healthy persons subsidize the care received by unhealthy persons,”¹⁴⁸ rather than a model which would be “actuarially fair.”¹⁴⁹

It is easy to sympathize, even without fully subscribing to Crossley’s solidarity model. Stories of people denied life-saving medical care precisely when they need it the most represent a horrifying prospect. It is similarly troubling to contemplate, as the President does,¹⁵⁰ people who can never purchase insurance in the first place, or who are denied renewal. Accordingly, PPACA illegalizes denials, rescissions, and discriminatory pricing. A normal market pushes insurers to charge an *experience rate* based on that individual’s past experience. PPACA forces insurers to

145. See Crossley, *supra* note 10 (emphasis added).

146. Obama, *supra* note 6. The original testimony was reported by NPR. See Silberner, *supra* note 15.

147. See Silberner, *supra* note 15.

148. See Crossley, *supra* note 10, at 1.

149. *Id.* at 78 (describing actuarial fairness: “each individual should bear financial responsibility for his own risk of incurring medical expenses”).

150. See Obama, *supra* note 6.

charge a *community rate*—a consistent premium which ignores health status. The bill hopes that this will provide health insurance access for even the sick and the disabled. Community rating is an economic term, but it also represents aptly the chief goal of PPACA.

More than anything else, health reform institutes the solidarity model of health insurance, effectively desegregating basic access to health care. In so doing, however, it exacerbates another problem: adverse selection. That dilemma has always threatened health insurance, but it becomes particularly poignant in the face of community rating. Necessarily, therefore, PPACA institutes an attempted solution: the mandate.

B. Adverse Selection and the Mandate

The constant threat to insurance, as outlined by 2001 Nobel Prize winner Joseph Stiglitz and co-author Bruce Greenwald in a landmark 1986 article,¹⁵¹ stems from the problem of asymmetric information. Any party which has more information than its economic partners can exploit that difference to gain an advantage—often destabilizing economic systems wholesale.

While health insurance was not the subject of Stiglitz's work, adverse selection is a particularly severe problem in medical economics, and is one of the dominant justifications for government intervention.¹⁵² As framed by Professor Charles Phelps:

[A] lingering question persists, at least in theory, about the intrinsic stability of the health insurance market. The problem hinges on the difference in information held by buyers of insurance (consumers) and sellers of insurance (insurance companies). The buyers know more about their own health than the sellers. Thus, the risk exists that insurance companies will put an insurance plan into the market that uses one set of actuarial projections about the costs of insured people but ends up attracting a special subset of the population with unusually high health care costs. Obviously, the insurance company would go broke if this happened repeatedly. This is called the problem of . . . “adverse

151. Bruce C. Greenwald and Joseph E. Stiglitz, *Externalities in Economies with Imperfect Information and Incomplete Markets*, 90 Q.J. ECON. 229 (1986).

152. Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89 (2001).

selection.”¹⁵³

Private market health insurance, at least until PPACA was passed, depended on combating adverse selection. Insurers worked studiously to avoid bad health risks because healthy customers “obviously do not want [sicker] people in their insurance pool, because the average costs and hence the premiums will be driven up.”¹⁵⁴ The entire health insurance market, therefore, becomes vulnerable to “‘bad risks chasing good risks.’ . . . people racing from group to group in a frenzy of sickly people seeking coverage and healthy people trying to evade sickly people.”¹⁵⁵ Sustainably profitable plans, therefore, were those which excelled at evading that pool of less-healthy patients. Any plan that failed to do this would fall prey to the famous “death spiral” of adverse selection.¹⁵⁶

This was seen most dramatically in an accidental 1995 experiment.¹⁵⁷ Harvard University shifted from a conventional, employer-subsidized system to a voucher system. It paid employees a certain amount and they selected an insurance plan and paid for the difference themselves.¹⁵⁸ Employees suddenly bore the costs of selecting a higher-cost plan, and economists correctly suspected that healthy employees would gravitate towards the lowest-coverage plan. “Consistent with the theory,” reported Professor David M. Cutler, “the policy change induced substantial adverse selection. Within three years of the pricing reform, adverse selection eliminated the market for more generous insurance entirely.”¹⁵⁹

Classically, insurance plans cohere largely because the transactions costs associated with employer-based insurance prevent too much movement in insurance markets.¹⁶⁰ But adverse selection nonetheless lurks

153. CHARLES E. PHELPS, *HEALTH ECONOMICS* 334 (3d ed. 2003).

154. *Id.*

155. *Id.*

156. See Anemona Hartocollis, *New York Offers Costly Lessons on Insurance*, N.Y. TIMES, Apr. 17, 2010, available at <http://www.nytimes.com/2010/04/18/nyregion/18insure.html> (utilizing the term “death spiral”).

157. David M. Cutler and Sarah J. Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q.J. ECON. 433 (1998).

158. *Id.* at 434.

159. *Id.* at 434-435. Cutler and Reber do, however, report net benefits associated with the move.

160. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23 (2001).

in the system, and PPACA's imposition of community rating will exacerbate it dramatically. Accordingly, when the President and Congress wanted to provide coverage to bad-risk candidates, they had to address the problem of adverse selection.

The most obvious way to do so is, of course, to impose a law that prevents good risks from fleeing. Classically, this is done via mandated benefits. As elaborated by Larry Summers in 1989,¹⁶¹ mandated benefits prohibit the offering of any package—in this case, any health insurance plan—which omits certain benefits. These sorts of mandates do not require individuals to purchase insurance, but those who choose to do so must buy a certain amount of coverage.

The benefit is obvious: mandates dramatically alleviate the problem of adverse selection, since good risks cannot flee to a low-coverage plan. For example, women usually have better knowledge than insurers regarding their own childbearing plans. Women who do not plan on having children thus tend to exit any plan that offers maternity coverage—and such plans fall into the death spiral. By forcing all insurers to cover maternity care, women who *do* plan on having children can find coverage because all plans face an even playing field.

The problem here is also obvious: with too high a floor, good risks will exit the health insurance market entirely. Indeed, PPACA specifies that all plans must include obstetrics coverage even for men—obviously a useless feature. Many “good risks” will similarly feel that coverage for substance abuse rehabilitation and other such services is not worth the additional premiums. If enough of a plan is comprised of such services, those individuals might exit the insurance market entirely—either self-insuring or, as Summers¹⁶² and the President¹⁶³ describe, forcing others to bear the costs of their care.

161. Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, AEA PAPERS AND PROCEEDINGS, May 1989, at 179. Summers' examples of adverse selection involve healthy employees fleeing employers who offer too-expensive insurance, but the same idea applies to insurance plans more broadly. He does give the specific example of a health plan that includes AIDS benefits. *See id.* at 179, n.1.

162. *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”).

163. *See* Obama, *supra* note 6 (“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 235-236 and text accompanying (arguing that the President's point is not persuasive).

And so PPACA takes the direct solution and imposes a complete mandate. Classic mandates regulate underinsurance, but PPACA progresses to regulating *un*insurance. Its fine on uninsurance decreases the opportunity cost of coverage and thus functions like a subsidy. If successful, the mandate will prevent adverse selection and death spirals.

The mandate was designed to solve adverse selection, but it raises a problem of its own: it would be absurd to impose a mandate on people who could not afford insurance. One could, of course, simply build in a hardship exemption, and PPACA does so. But that hardship exemption alone would be 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, PPACA attempts to provide a solution.

C. Expenses and Subsidies

The cost of medical insurance is rising quickly. Between 1999 and 2008, cumulative increase in health insurance premiums was 119%, compared with cumulative inflation of just 29%.¹⁶⁴ In New York, the highest-cost state, a family plan now costs an average of \$13,296.¹⁶⁵ When viewed in the context of costs like these, a mandate compelling a family to buy insurance can appear positively cruel. PPACA thus imposes the most direct solution: a subsidy.

As described above,¹⁶⁶ PPACA's subsidies are, from a consumer's perspective, designed 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.

Additionally, PPACA addresses a related concern: underinsurance. Professor Elizabeth Warren—now in the Obama Administration—and others have published statistics arguing that more than half of bankruptcies are caused by medical-related phenomena.¹⁶⁷ Most recently, Professor

164. See Kaiser Family Found., Trends in Health Care Costs and Spending 2 (2009), http://www.kff.org/insurance/upload/7692_02.pdf.

165. America's Health Insurance Plans, *supra* note 26.

166. See generally *supra* Part I.C.

167. See, e.g., David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. W5-67 (Web Exclusive Feb. 2, 2005) (“Slightly more than half (54.5 percent) . . . met criteria for ‘any medical bankruptcy.’”).

David Himmelstein and others have argued that 62% of bankruptcies can be traced to a medical problem.¹⁶⁸ These sorts of statistics have been hotly disputed,¹⁶⁹ but the President appears to have internalized their underlying claims.¹⁷⁰ Most frighteningly, many of these experts argue forcefully that health insurance was often not enough to stem these financial disasters.¹⁷¹ Between deductibles, co-pays, and coinsurance, many of these families fell into financial hardship despite the presence of insurance. Even routine medical bills, Professor Melissa Jacoby argues, can help push families into bankruptcy.¹⁷²

These cost-sharing provisions may cause even insured families to ration needed medical care,¹⁷³ exacerbating underlying problems and increasing overall medical expenses. This seems to defeat the solidarity purpose of health insurance: to help provide medical care for those who most need it.

Whatever the merits of the underlying methodological dispute, Professor Warren's work is compelling at least as a narrative, and the

168. David U. Himmelstein, Deborah Thorne, Elizabeth Warren & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 742 (2009).

169. See, e.g., David Dranove & Michael Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFF. w78 (2006)

170. See Obama, *supra* note 6 (“Everyone in this room knows what will happen if we do nothing. . . . More families will go bankrupt.”).

171. See Himmelstein et al., *supra* note 167 (claiming that among “medical debtors . . . three-fourths (75.7 percent) of these debtors were insured at the onset of the bankrupting illness.”).

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

173. See, e.g., *id.* at 247 n.30 (“This point is frequently made.” (citing PETER J. CUNNINGHAM & LAURIE E. FELLAND, FALLING BEHIND: AMERICANS’ ACCESS TO MEDICAL CARE DETERIORATES, 2003-2007, 2 (Center for Studying Health Sys. Change, Tracking Rep. No. 19, 2008), available at <http://www.hschange.com/CONTENT/993/993.pdf> (noting cost was —most frequently cited—and growing—obstacle to care!); Cathy Schoen et al., *In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008*, 28 HEALTH AFF. w1, w5 (2008) (discussing cost-related deterrence of treatment, particularly among U.S. patients); Robert W. Seifert & Mark Rukavina, *Bankruptcy Is the Tip of a Medical-Debt Iceberg*, 25 HEALTH AFF. w89, w90 (2006)).

President's comments seem to indicate that he shares her concerns.¹⁷⁴ Indeed, the bill itself recites her findings.¹⁷⁵ Accordingly, PPACA 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 is not permitted to impose any further cost-sharing.¹⁷⁶

Still, for many families, \$4,500 would be a significant burden. The bill therefore also provides government subsidies for cost-sharing—preventing the “underinsurance” problem that so many bankruptcy articles raise. For families between 100% and 400% of the FPL, the government pays for 70-94% of their out-of-pocket expenses,¹⁷⁷ dramatically reducing the burden of premiums and the incentive to self-ration.

By making health insurance and cost-sharing affordable, subsidies thus solve the problems caused by mandates. And yet they create their own problem: the government must find the money to pay for them.

D. Deficits, Taxes, and Spending Cuts

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.¹⁷⁸ In other words, the “pay-as-you-go” rule prohibits any legislative package that would, on balance, worsen the deficit.¹⁷⁹ PPACA imposes a variety of new spending measures, including subsidies and Medicaid expansions. To comply with PAYGO Rules—and, probably, for political reasons—Congress included several revenue-raising provisions to ensure that CBO could project a deficit reduction.

174. *See* Obama, *supra* note 6.

175. PPACA, Pub. L. No. 111-148, § 1502(a)(2)(E) (2010) (“Half of all personal bankruptcies are caused in part by medical expenses.”).

176. *See* PPACA § 1302(c)(1), I.R.C. § 223(c)(2)(A)(ii), I.R.C. §§ 223(c)(2)(B)(ii).

177. *See supra* p. 10, tbl.2.

178. Statutory Pay-As-You-Go Act of 2010, 2 U.S.C. § 931.

179. CBO specifically points out that “pay-as-you-go procedures would apply” to PPACA and HCERA. *See* Letter from CBO, *supra* note 13.

Table 3: CBO Estimated 2010-2019 Deficit Effects (in billions of dollars, with negative numbers denoting deficit reductions)¹⁸⁰

Spending Increases	
Subsidies via Premium Tax Credits	350
Medicaid Expansions	434
Exchange-Related Spending	7
Other Changes in Direct Spending	30
Spending Decreases	
Reduction in Physician Fee For Service Schedule	-332
Medicare and Medicaid DSH Payment Reductions	-36
Other Medicare, Medicaid, and CHIP Provisions	-87
Decreased Reimbursement for Community Living Assistance Services	-70
Increases in Tax Revenue	
Mandate Fine	-65
"Cadillac Tax"	-32
Associated Effects of Coverage Provisions	-46
Industry Fees	-107
Hospital Insurance Tax	-210
Other Revenue Provisions	-103
Decreases in Tax Revenue	
Subsidies via Premium Tax Credits	144
Total Change in Deficit	-123

CBO's estimates indicate that the bill'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 appear to project any overall reductions in medical spending from preventive care measures.

Finally, of course, Congress wanted to ensure that the expansions in

180. See CBO, *supra* note 13, tbl.2.

insurance would, indeed, increase access to health insurance. CBO estimated that they would:

Table 4: CBO Estimates on Changes in Insurance Coverage (in millions of uninsured people)¹⁸¹

Program	Enrollees
Medicaid and CHIP	+16
Employer	-3
Nongroup and Medicare	-5
Exchanges	+24
Total Uninsured	-32

CBO’s estimates, then, accord very clearly with the President’s stated desires: PPACA prevents certain insurance behaviors like rescission; it helps reduce the ranks of the uninsured through Medicaid expansions and subsidies; and, according to CBO, it will reduce federal deficits.

The so-called “Cadillac tax,” of course, is designed to generate revenue—about \$32 billion, according to CBO’s estimates.¹⁸² It also, however, serves a second purpose: to slow the rising costs of medical care. The excise tax is intentionally indexed not to medical inflation, but to general consumer inflation. If health premium growth continues to outpace general inflation, then over time a greater and greater proportion of plans will fall into “Cadillac” territory.

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 the health insurance is purchased with before-tax dollars.”¹⁸³ The amount of this subsidy, as of 1994, was estimated to be as much as \$90 billion.¹⁸⁴ The Cadillac tax begins to remedy this in the most obvious way: by closing the loophole, starting with the most expensive plans and gradually expanding to

181. *Id.* at tbl.4.

182. *See supra* tbl.3.

183. PHELPS, *supra* note 153, at 345.

184. *Id.* at 350.

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?”¹⁸⁵ If this tax functions as designed, employees would shy away from high-cost plans;¹⁸⁶ the most expensive benefits would probably be dropped from most plans without harming actual health;¹⁸⁷ and, hopefully, the money saved can take the form of higher wages.¹⁸⁸

Most importantly, as Leonhardt argues:

This tax break causes us to buy more health insurance than we would if the playing field for taxes were level, much as the tax breaks for housing helped inflate the real estate bubble. In effect, the tax-free treatment is a subsidy for health insurers, doctors and hospitals. 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.¹⁸⁹

If Leonhardt’s predictions prove true, then these inflated insurance plans, which lead to excess demand for medical services, would be dramatically reduced. Accordingly, the Cadillac tax would accomplish much more than deficit reduction—it would slow medical spending as a whole and thus save money for Medicare, Medicaid, and the private sector.¹⁹⁰

While most of the tax increases are designed to directly reduce the

185. David Leonhardt, *Economic Scene: How a Tax Can Cut Health Care Costs*, N.Y. TIMES, Sept. 29, 2009, <http://www.nytimes.com/2009/09/30/business/economy/30leonhardt.html>.

186. *Id.*

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

188. *Id.* (“wage increases are often meager when insurance premiums are growing quickly”).

189. *Id.*

190. 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.*

deficit, we thus see that some of them were also designed to slow the growth of overall medical spending. If they succeed, they will help make insurance more affordable not just for individuals, but for the nation as a whole. These taxes are designed to help pay for the subsidies that enable the rest of the bill—and, in so doing, they make the entire reform package possible.

E. The Philosophical Core and Political Robustness

The core of the bill, we now see, is in fact a single coherent plan, not an assortment of ideas. It also addresses related concerns—the burden of cost-sharing, rising premiums, and others—but it has four essential components. First, its central provision is enforced community rating. Community rating exacerbates adverse selection, and so PPACA imposes an insurance mandate. The mandate would be self-defeating and cruel without subsidies, and so PPACA provides them. Subsidies are expensive, and deficit spending would be politically unpopular and would violate PAYGO, and thus 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 at times when the bill as a whole was very controversial, the bill’s central provision has always been popular. As explained in October by Gallup:

President Obama has remarked that there is widespread agreement in Washington on certain aspects of reform, such as *requiring insurance companies to cover those with pre-existing medical conditions, prohibiting insurance companies from dropping those who get sick, and providing assistance to lower-income Americans to help them obtain insurance. Despite lukewarm support for a new healthcare bill in general, existing polling from Gallup and other firms finds Americans expressing strong support for provisions such as these, or saying these are highly important to include in healthcare legislation.*¹⁹¹

David Frum, a fellow at the American Enterprise Institute and a former senior advisor to President Bush, agrees:

191. Frank Newport, Jeffrey M. Jones, and Lydia Saad, *Americans on Healthcare Reform: Five Key Realities*, GALLUP, Oct. 30, 2009, <http://www.gallup.com/poll/123989/americans-healthcare-reform-five-key-realities.aspx> (emphasis added).

Some Republicans talk of repealing the whole bill. That's not very realistic. . . . Do Republicans write a one-sentence bill declaring that the whole thing is repealed? Will they vote to reopen the "doughnut" hole for prescription drugs for seniors? To allow health insurers to deny coverage to people with pre-existing conditions? To kick millions of people off Medicaid?

It's unimaginable, impossible.¹⁹²

The bill's central provision is politically popular, and that renders the entire bill politically robust.¹⁹³ If Frum and Gallup are right that the central provision is too popular to repeal, 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—for example, Frum suggests repeals of certain particular taxes¹⁹⁴—but, fundamentally, the bill originates from a place of political strength. That strength served as the President's rhetorical base during advocacy, helped the bill's passage, and now renders the bill effectively unrepeatable.

It is easy to see PPACA as mishmash of unrelated ideas, but this Note demonstrates the incorrectness of that notion. This legislation was specifically designed around one simple idea: that insurers should treat the healthy and the sick alike. It is a bill built around Crossley's model of solidarity, and each of its core provisions is meant to defend that idea.

III. PAVED WITH GOOD INTENTIONS

We thus see the bill's intended effects—but its actual effects are another thing entirely. Will reform really lower costs, expand access, and provide security? Part III of this Note provides the comprehensive picture necessary to examine that, and concludes that the bill is likely to result in dramatic failure. Fundamentally, *the math does not work*. Health insurance

192. David Frum, How GOP Can Recover from its 'Waterloo,' CNN.COM, Mar. 22, 2010, <http://www.cnn.com/2010/OPINION/03/22/frum.healthcare.gop.strategy/index.html> (emphasis added).

193. See Ady Barkan, J.D. Candidate, Yale Law School, Address to Yale Law School American Constitution Society: What's Next? Implementing and Expanding the Health Care Law (Apr. 8, 2010).

194. See Frum, *supra* note 192.

will become too expensive, the mandate will be inadequate, insurers will find new ways to discriminate, and medical expenses will continue to rise along with the federal deficit. PPACA attempts to force too many people to behave too contrary to their interests, and this will leave our national health system in—to borrow the term—a death spiral.

None of this is certain or inevitable. Health care delivery depends on a series of stakeholders, each necessary to providing access to medical care. Accordingly, a great deal of the bill's ultimate shape has not yet been decided. Congress, HHS, the states, the insurance industry, physicians, and the American people as a whole each have a part to play in determining the ultimate success or failure of the PPACA.

A. Solidarity and Insurance Gamesmanship

The central provision of the PPACA appears, at first glance, to be its most robust. Insurers are no longer allowed to reject or charge higher premiums to those with preexisting conditions. However, several more subtle forms of discrimination remain on the table—and the incentive to engage in them is heightened. According to health economist Mark V. Pauly, PPACA probably “increase[s] the incentive for cherry-picking,” since “I’m strongly motivated to try to avoid you if I’m not allowed to charge you extra.”¹⁹⁵

In fact, immediately in the wake of the bill, one insurance industry lawyer pointed out that insurance companies had limited obligations with respect to children. They did “not have to sell to somebody with a pre-existing condition” until 2014, and “the insurer could increase premiums to cover the additional cost.”¹⁹⁶ Congressional Democrats were furious, with Senator John D. Rockefeller IV saying, “The ink has not yet dried on the health reform bill, and already some deplorable health insurance companies are trying to duck away from covering children with preexisting conditions. This is outrageous.”¹⁹⁷ Under White House pressure, America’s Health Insurance Plans, a trade group, quickly agreed

195. David S. Hilzenrath, *Economic Agenda: Discrimination by Insurers Likely Even with Reform, Experts Say*, WASH. POST, Oct. 4, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/03/AR2009100302483.html>.

196. Robert Pear, *Coverage Now for Sick Children? Check Fine Print*, N.Y. TIMES, Mar. 28 2010, <http://www.nytimes.com/2010/03/29/health/policy/29health.html>.

197. *Id.*

to comply with impending Obama administration rules.¹⁹⁸ Press Secretary Robert Gibbs scored the encounter as “Kids 1, insurance 0.”¹⁹⁹ Gibbs’s comment was entertaining, but it was also revealing: this provision runs directly contrary to insurers’ interests, and the White House knows it. The years to come will likely see an ongoing confrontation between private insurers and government attempts to force it to comply with PPACA’s intentions.

And, indeed, several tools remain on the table for the insurance industry. While a great deal will depend on HHS’s decisions regarding essential health benefits, insurers are very experienced in subtle forms of “cherry-picking.” To give the classic example: insurance companies often offer gym memberships, a bonus which only provides value to those healthy enough to use such equipment.²⁰⁰ Health insurers can also be uncooperative on insurance claims, which would disproportionately affect the chronically ill.²⁰¹ Even insurance plans marketed to the elderly tend to offer benefits that attract low-risk patients: health club membership, eyeglasses, and preventive dental care.²⁰² And while insurance plans would have 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.²⁰³

A great deal also depends on what HHS defines as an “essential benefits package.” While much is prescribed by the bill, HHS also retains significant authority.²⁰⁴ HHS Attorney Jessica Mantel has argued that adverse selection will force most plans down to the minimum essential benefits package.²⁰⁵ To compensate, she believes that the political process

198. Robert Pear, *Insurers To Comply with Rules on Children*, N.Y. TIMES, Mar. 30, 2010, <http://www.nytimes.com/2010/03/31/health/policy/31health.html> (“‘Health plans recognize the significant hardship that a family faces when they are unable to obtain coverage for a child with a pre-existing condition,’ said Karen M. Ignagni, president America’s Health Insurance Plans. . .”).

199. *Id.*

200. See Hilzenrath, *supra* note 195.

201. *Id.*

202. *Id.*

203. *Id.*

204. See *supra* text accompanying notes 44-45.

205. See Jessica Mantel, *Health Care Reform: Setting National Coverage Standards for Health Plans*, 57 UCLA L. REV (forthcoming 2010) (“only individuals who anticipate needing treatment for these conditions would purchase the supplemental coverage, leaving insurers unable to balance the costs of covering the conditions across a large risk

will lead to a high floor.²⁰⁶ Patient lobbying groups will demand coverage for their conditions; more troublingly, provider lobbying groups (such as chiropractors or fertility specialists) might demand coverage to ensure demand for their services. This would drive up costs,²⁰⁷ but with one benefit: some of the cherry-picking techniques described above would be off the table. HHS could, for example, require that plans have a reasonable number of nephrologists staffing dialysis centers; or it could require all plans to include gym membership, preventing plans from using that as a screening device.

Even beyond the benefits offered, however, insurance plans could still engage in “cherry-picking.” 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,” with an advertising campaign built around the idea that “You’re young. You’re healthy. You’re in shape.”²⁰⁸ Insurance companies could market themselves among younger demographics, such as college students or Starbuck’s customers. Small fonts, offices without elevators, and agents who operate exclusively out of suburbs could also become standard practices.

Technology, too, offers insurers ways to game the system. Companies could market themselves exclusively via emerging social networks such as Facebook or Twitter, or via an application exclusive to Apple’s iPhone. 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 software²⁰⁹—could just as easily be used to screen out those who type slowly, have trouble reading, have weak English skills, or are simply unused to computers. Each of these screening techniques becomes more important in light of PPACA’s anti-discrimination provisions.

Fully aware of this threat, Senator Max Baucus (D-Mont.) originally proposed a plan that called for the creation of a kind of baseline risk-

pool that includes healthy individuals”).

206. *Id.* (“political considerations would lead politicians to push for an essential health benefits package that includes those conditions and treatments demanded by the public or influential special interest groups, regardless of the merits”).

207. *Id.*

208. See Hilzenrath, *supra* note 195.

209. See Lev Grossman, *Computer Literacy Tests: Are You Human?*, TIME, June 5, 2008, <http://www.time.com/time/magazine/article/0,9171,1812084,00.html>.

adjustment: insurers that ultimately covered disproportionately sick populations would receive higher compensation.²¹⁰ This provision would have been highly complicated²¹¹ and was ultimately dropped. Still, Senator Baucus's plan could be reinstated if Washington saw it as necessary.

Whether PPACA actually succeeds in implementing meaningful community rating and Crossley's solidarity model depends on a number of factors. In particular, it depends on ultimate outcome of this three-way melee between Congress, HHS, and the insurance industry. Again, however, a too-successful implementation of community rating risks pushing healthy populations to opt out of insurance altogether.

B. The Mandate: Fines, Premiums, and Civic Duty

If, as Mantel fears, HHS faces pressure to establish a high-benefit insurance package, then more and more healthy Americans will face pressure to drop insurance entirely. The prices of the premiums will continue to rise for diminishing marginal gains—giving Americans an incentive to drop coverage. The mandate is designed precisely to prevent this—but, if premiums rise too high, the fine may not be enough 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.”²¹² While on the subject, the author strongly urged readers to short sell every major health insurance company on the theory that they would be pushed into bankruptcy.²¹³ The blog was incorrect as to the magnitude of the fine²¹⁴—a potentially serious error—but the underlying premise remained: based on a prediction of very large premium increases²¹⁵ on par with those seen prior to credit card rate

210. See Hilzenrath, *supra* note 195.

211. Among other things, it is not clear why insurers would be receiving compensation from the federal government in the first place.

212. Posting of Karl Denninger to Market Ticker, *Health Care: Arbitrage Obama and the Dems*, <http://market-ticker.denninger.net/archives/2109-Health-Care-Arbitrage-Obama-And-The-Dems.html> (Mar. 22, 2010, 1:23PM EST).

213. *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.”).

214. *Id.* (“a sliding scale that amounts to 2% of your AGI”).

215. *Id.* (“The “cheapest” acceptable policy will cost somewhere around \$15,000 for

regulation,²¹⁶ it accordingly urged readers to drop health care coverage until such time as they become ill.²¹⁷

If those assumptions prove correct, then the dire predictions foretold by the author make a great deal of sense. 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 \$12,000²¹⁸—approximately double the current national average.²¹⁹ Plans could rise by \$6,000 a year or more.

This projection, roughly speaking, is not ridiculous. As families face more and more of an incentive to buy insurance—both because of the subsidy and the fine—simple supply and demand economics will drive up the price. More importantly, if insurers are not allowed to discriminate against the unhealthy, their own costs are likely to spike—and premiums will have to rise accordingly. When the state of New York imposed a similar non-discrimination requirement,²²⁰ its premiums spiked to the highest in the nation: currently \$13,296 for an individual market family plan.²²¹ New York does not have a mandate—but Massachusetts, which does, is the second most expensive: the average family plan costs \$13,288.²²² The dropoff is steep: the fourth-most expensive state, Maine, has an average family plan of just \$7,260.²²³ For CBO to project insurance

a single person, and over \$20,000 for a family. This is, for most people, more than five times the maximum possible fine”).

216. *Id.* (“This is precisely what the banks did in front of the CARD act becoming effective, and it will happen here as well.”).

217. *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 in original). Denninger notes the risk of a “zero-notice catastrophe,” but urges readers to self-insure. *Id.*

218. Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to Olympia Snowe, U.S. Sen. (Jan. 11, 2010), http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf.

219. America’s Health Insurance Plans, *supra* note 26, at 4.

220. *See* Hartocollis, *supra* note 156 (“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.”).

221. America’s Health Insurance Plans, *supra* note 26, at 6 tbl.3.

222. *Id.*

223. *Id.* Maine is the fourth-most expensive state according to Table 3, which ranks

costs into the \$12,000 range once federal regulation resembles that in Massachusetts and New York, then, is not ridiculous.

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 bill'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; imposing a fine gives them incentive to keep it. But the incentive to drop, in this analysis, is stronger than the incentive to keep unless a family is making more than \$244,000 a year.²²⁴ Moreover, PPACA explicitly states that failure to pay the fine cannot result in criminal prosecution, liens, or levies.²²⁵ 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 require fines until a family had income of \$150,000—rendering the mandate nearly hollow.²²⁶

Put another way: families below \$88,200 will usually have some incentive to keep insurance, since the government will subsidize it.²²⁷ A

by the price for a single person. The fourth-most expensive family plan is Connecticut's, at \$8,477—still a dramatic fall from Massachusetts and New York. *Id.*

224. The 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. Most families probably have some current economic rent—that is, 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 160 (“most 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 well begin to self-insure when hit with a higher premium bill—again helping to make this estimate conservative in this respect.

225. PPACA, Pub. L. No. 111-148, § 1501(b) (2010).

226. *See supra* note 48 and text accompanying.

227. The government subsidy would cap premiums at 9.5% of income. *See supra*

family above \$244,000 has an incentive to keep insurance, because the fine is much higher than the money they would. *Any family in-between would be economically 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 would be 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 great deal of assumptions that will almost certainly have to be somewhat 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 would cost \$19,200.²²⁸ If these numbers turn out to be even remotely close to reality, then insurance markets will completely collapse except insofar as government subsidies manage to prop them up.

There are several potential policy solutions to this. The most obvious is rate regulation. The underlying assumptions of CBO's estimates are unclear, but if they assume large industry profits, this would be a viable approach. If, as seems more likely, draconian premium regulation would simply drive insurers into bankruptcy, then regulation is not a solution. Second, mandate fines could be dramatically escalated. Again, however, fines must always be balanced: too high, and they will be either cruel or politically unenforceable.²²⁹ The third solution is, as Mantel suggests,²³⁰ to establish a low mandate floor in order to achieve cost control. If the floor is much, much lower than what CBO currently projects it to be, then premiums will be lower than projected, and the mandate will be, relatively speaking, more powerful. Of course, this has the effect of substantially undercovering the sick populations and thus undermining the solidarity model that is the driving force of health reform. Fourth and finally, one could let the markets collapse and use the resulting political energy to implement a new solution—perhaps a tax-financed public option, or

note 64. For a family making approximately \$88,200, 9.5% (\$8,379) would still be a substantial increase over current premiums. *See supra* text accompanying note 219.

228. Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, *supra* note 218.

229. *See* Hacker, *supra* note 55.

230. *See* Mantel, *supra* note 205.

perhaps even single-payer health care. If the subsidies continue to rise along with premiums, eventually the government will be paying for most insurance anyway.

Assuming that none of these options are appealing to the designers of the bill, then there remains one option. If the mandate cannot succeed on its economic merits, then it will have to succeed out of a sense of social responsibility.²³¹

Can President Obama, in Kennedy-esque fashion,²³² motivate the American people to see purchase of insurance coverage as a civic duty? It seems unlikely. Professors David Hyman and Mark Hall observe that “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*.”²³³ Can the President 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?

His addresses to the America people, thus far, have not attempted this. He has appealed to individual responsibility to purchase insurance, but only such insurance as would cover a citizen’s *own* costs:

[E]ven 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

231. In addition to whatever spirit of solidarity our national leaders can muster, there is the consideration that some may wish to obey the mandate simply because it is law. For a more detailed discussion of “expressive law,” see Maggie Wittlin, *Buckling Under Pressure* 3 (July 1, 2009) (unpublished manuscript) (“ . . . 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.”)

232. Lillian Goldman Law Library, *Inaugural Address of John F. Kennedy*, Yale Law School, http://avalon.law.yale.edu/20th_century/kennedy.asp (“Ask not what your country can do for you—ask what you can do for your country.”)

233. See Hyman and Hall, *supra* note 160, at 26 (emphasis added).

can't be achieved.²³⁴

President Obama here appealed to the young and the healthy to make sure that their own expenses were paid for—but failed to urge them to take a broader sense of social responsibility. Doing so might have opened the President to political attacks, but it might have made the bill more likely to succeed. More to the point, it would have been honest. In our nation, the lowest-spending 50% of the population incurs only 3% of medical expenses,²³⁵ and the highest-spending 5% incurs 50% of the expenses²³⁶—a per-person difference of more than 150-fold. It is simply incorrect for the President to demand that healthy individuals purchase insurance to prevent spillover costs to the unhealthy.

Unfortunately for the system as a whole, CBO's estimates of the price of insurance appear to be roughly correct: they 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 the death spiral of Congressionally-mandated adverse selection.

C. Expanded Access but Provider Exodus

Even if health insurance manages to cohere, there remains another vital step in health delivery: doctors. “What if,” asks a physician recruitment firm, “nearly half of all physicians in America stopped practicing medicine?”²³⁷ It is a ridiculous question, as even the search firm acknowledges,²³⁸ but it is rooted in legitimate concerns. The firm, Medicus, reported in January that nearly one-third of physicians indicated

234. See Obama, *supra* note 6 (emphasis added).

235. Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, Agency for Healthcare Res. & Quality Research in Action, June 2006, at 1, available at <http://www.ahrq.gov/research/ria19/expendria.pdf>.

236. *Id.* at 1.

237. Andrea Santiago, *The Medicus Firm Physician Survey: Helth Reform May Lead to Significant Reduction in Physician Workforce*, MEDICUS FIRM, Jan. 2010, <http://www.themedicusfirm.com/pages/medicus-media-survey-reveals-impact-health-reform>.

238. *Id.* (“seems unlikely”).

they would leave medicine if health reform passed.²³⁹ As Medicus points out, physicians are notorious for claiming that they will leave medicine²⁴⁰—especially in self-selected samples—and the claim has not historically proven true. Medicus nonetheless expresses two concerns. First, if even some physicians do exit medicine, this could exacerbate an already-projected shortage.²⁴¹ Second, “there could be an impact in quality of care due to a lack of morale.”²⁴²

And yet Medicus seems to forget about 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 and some have even exited the business of dealing with health insurance entirely. And so PPACA finds itself facing another battle: even if it successfully provides affordable health insurance, it may still fail at providing actual medical care.

Already, many patients on Medicaid report difficulty accessing physicians who are willing to see them.²⁴³ *The Wall Street Journal* reported the story of one such 16-year old Medicaid patient with severe joint pain.²⁴⁴ “When we had *real* insurance,” said her mother, “we could call and come in at the drop of a hat.”²⁴⁵ Such stories are not isolated: 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 many of those also cap or refuse to accept new Medicaid patients.²⁴⁶ The director of one of Michigan’s Medicaid plans reports the difficulty: “We literally get on the phone with doctors and beg.”²⁴⁷

239. *Id.*

240. *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.”)

241. *Id.* (“The Bureau of Labor Statistics . . . predicts a more than a 22 percent increase in physicians jobs” by 2018.).

242. *Id.*

243. 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.”).

244. *Id.*

245. *Id.* (emphasis added).

246. *Id.*

247. *Id.*

The reasons for this are multiple-fold, but the most commonly reported reason is that Medicaid pays such low rates that most physicians cannot afford to care for substantial proportions of Medicaid patients.²⁴⁸ Physicians also report that they have trouble dealing with such patients in private practice contexts due to administrative hassles and no-show patients.²⁴⁹ For concerns like these, increased funding may not actually be an answer. Some physicians even worry that Medicaid patients are more prone to the sorts of medical difficulties that can lead to malpractice suits.²⁵⁰ The problem has reached particularly severe levels among dental practices²⁵¹—perhaps a foreshadowing of what medical care might look like post-reform.²⁵²

An even more extreme version of this phenomenon involves “retainer care”—often referred to as “concierge medicine”—a practice setup in which physicians focus their attention on those willing to pay a retainer

248. *Id.* (quoting one physician who takes Medicaid patients: “[W]e’re the ones getting killed.”).

249. *Id.*

250. Kevin Sack, *As Medicaid Payments Shrink, Patients Are Abandoned*, N.Y. TIMES, March 15, 2010, <http://www.nytimes.com/2010/03/16/health/policy/16medicaid.html> (“She also said she feared being sued by Medicaid patients because they might be at higher risk for problem pregnancies, because of underlying health problems.”).

251. Medicaid patients’ lack of access to dental care has been a longstanding problem. 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-won-t-fix-poor-children-s-bad-teeth.html>. *See also* Alex Berenson, *Boom Times for Dentists, but Not for Teeth*, N.Y. TIMES, Oct. 11, 2007 (“[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*, ABC NEWS, April 7, 2010, <http://abcnews.go.com/US/wireStory?id=10306026> (reporting efforts of private practice dentists to shut down a clinic which cares for Medicaid patients).

252. *See* Reeves, *supra* note 251.

fee and drop the rest of their patients.²⁵³ Patients trade enhanced access for cash, thus providing a way for physicians to evade insurance markets entirely by charging relatively flat fees to a handful of wealthy patients. This is a critical threat to the system of cross-subsidization which proponents of solidarity insurance value so highly:²⁵⁴ if physicians insist on caring only for patients who can afford to pay large up-front fees, then no amount of insurance regulation will provide universal access to medical care.

PPACA's Medicaid expansions thus depend heavily on increasing the ranks of the insured *precisely via a method that may soon become irrelevant*. Of course, new Medicaid coverage will prove useful for emergently ill patients, but the expansion also represents a potential exacerbation of ongoing access problems. Moreover, it is not obvious that low-level Exchange plans would fare any better than Medicaid. If even a moderate number of physicians refuses to accept these patients—either by insisting on other insurance plans, by shifting into retainer care, or simply by quitting—then the problem of the underserved will simply shift from insurance to physicians. And PPACA does itself no favors by proposing \$332 billion in additional Medicare cuts,²⁵⁵ which might accelerate the movement of physicians into retainer arrangements.

Congress has a few mostly unpleasant tools at its disposal. Already, PPACA has made retainer care more expensive, since retainer care alone will not satisfy the mandate. Alternatively, Congress could simply increase Medicare and Medicaid reimbursement while decreasing the hassle associated with these programs—probably the simplest, most effective, and most direct approach. Of course, such an increase would have other budgetary ramifications.²⁵⁶

Finally, Congress could also attempt to force physicians to accept Medicare and Medicaid patients—not entirely preposterous, since

253. See Frank Pasquale, *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response*, 7 YALE J. HEALTH POL'Y L. & ETHICS 39 (2007).

254. *Id.* (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”).

255. See *supra* tbl.3; but see *infra* Part III.D (arguing that these cuts are unlikely to materialize).

256. See *infra* Part III.D (pointing out that PPACA would have violated statutory “pay-as-you-go” requirements and thus been illegal had such changes been originally present).

residency training is funded through government outlays and could theoretically be made contingent on some sort of reciprocity agreement.²⁵⁷ But such a move would probably provoke severe political outcry—in fact, fears of precisely this immediately prompted an attempt to amend the Missouri state constitution. As the Missouri State Medical Association explained:

SJR 25 . . . would submit to voters a constitutional amendment to provide that no law can compel a patient, employer, or health care provider to participate in any health care system. It would also provide that all persons and employers are free to pay directly for their health care services, and all health care providers are free to accept payment directly.²⁵⁸

This legislation seems absurdly paranoid, as PPACA has no provisions to force providers into government plans. Moreover, the bill would probably be helpless to stop federal regulation anyway. And yet it represents a genuine concern that PPACA may force providers out of insurance—and that Congress may subsequently try to force them back in.

D. Deficits: A Wink, a Nod, and the SGR

“I said at the beginning of this thing,” President Obama reassured a St. Louis crowd in early March, “we would not do anything that adds to our deficit.”²⁵⁹ Specifically, he told them of the PPACA: “This plan does not do anything to add to the deficit.”

CBO agrees with the President²⁶⁰—and yet it seems impossible, on its face, to extend coverage to 32 million more Americans without increasing the deficit. The additional taxes generated are a relative pittance compared to the additional outlays. In particular, I argue here that PPACA includes

257. For precisely such an advocacy, see Kevin Grumbach, *Fighting Hand to Hand Over Physician Workforce Policy*, 21 HEALTH AFFAIRS 13, 24 (2002) (“Medicare payments came with no strings attached for how many residents could be trained or in which specialties they would be trained.”).

258. SENATE DEBATES FREEDOM OF HEALTH CARE ACT (Missouri State Medical Association Legislative Report, March 25, 2010) (on file with author).

259. Shawn Tully, *Health care: Going from Broken to Broke*, FORTUNE, Mar. 12, 2010, http://money.cnn.com/2010/03/12/news/economy/debt_health_care.fortune/index.htm.

260. See *supra* Part II.D.

many spending cuts which Congress has no intention of actually implementing—and that it does so in order to make the bill appear as a deficit-reduction measure.

The accounting involved would have been impossible had S. 1776 passed in October. That bill, which proposed the elimination of Medicare's Sustainable Growth Rate formula, failed to make it out of cloture.²⁶¹ The American College of Physicians (ACP) decried that failure, arguing that S. 1776 would have “put an end to the cycle of annual Medicare cuts” that the formula pretended to threaten.²⁶² ACP President Joseph Stubbs argued:

For too many years now, Congress has enacted short-term patches to [prevent] the SGR cuts and used misleading budget gimmicks. . . . There is 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.²⁶³

It has become an annual—and sometimes monthly²⁶⁴—shell game for Congress to use Medicare cuts to reduce the deficit, and then prevent those cuts from ever actually taking effect. Congress's most recent steps, the AMA reported, actually “allow[ed] an unprecedented 21% cut officially to take effect twice before reversing it.”²⁶⁵ Fortune Magazine explains the underlying political analysis:

A law dating from 1987 sets strict limits on total physician payments for Medicare. . . . [S]ince 2002, Congress has been postponing those cuts and allowing modest increases in reimbursements instead. The official budget [CBO's estimate] assumes that Congress made the cuts every year, and hence starts with a far lower spending number. But that's fiction. Each year, Congress passes what it calls the “Doc Fix,” which

261. Joseph W. Stubbs, President, American College of Physicians, Press Statement, *ACP Statement on Senate Vote S. 1776*, Oct. 21, 2009, available at <http://www.acponline.org/pressroom/s1776.htm>.

262. *Id.*

263. *Id.*

264. Chris Silva, *Medicare Pay: SGR Fatigue*, AMEDNEWS, May 3, 2010, <http://www.ama-assn.org/amednews/2010/05/03/gvsa0503.htm>.

265. *Id.* Silva reports that the stress is actually pushing some physicians out of Medicare completely, mimicking for different reasons the provider exodus from Medicaid. *Id.*; see also *supra* notes text accompanying notes 243-252.

today requires spending about \$25 billion a year more than the budget projects.

The House included the “Doc Fix” in the bill it presented in July, but not the Senate. And now it's reappeared—but in a different piece of legislation. The administration estimates that the Doc Fix will cost \$371 billion over 10 years. Yet the CBO doesn't talk about that cost when it comes to health care—because it can't. It's not in the bill it's scoring.

“The bill has many changes in Medicare, but this is the only one Obama wants to do separately,” says James Capretta, who served in the Office of Management and Budget under President George W. Bush. “It's an attempt to hold the official cost below \$1 trillion, when it's really far higher.”²⁶⁶

All told, Fortune argued that PPACA will *increase* deficits by \$488 billion.²⁶⁷ As former CBO Director Douglas Holtz-Eakin complains, “the budget office 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.”²⁶⁸ His estimate is that the bill will actually increase deficits by \$562 billion—very similar to Fortune's estimate.²⁶⁹ According to Holtz-Eakin, the bill also ignores \$114 billion in discretionary spending which is mandated by but not technically included in the bill²⁷⁰—but, more importantly, Holtz-Eakin states the obvious: “Congress is likely to continue to regularly override scheduled cuts in payments to Medicare doctors.”²⁷¹

The problem is so obvious that CBO's report *itself* highlighted this as

266. Tully, *supra* note 259. For an unpersuasive defense of this accounting technique, see Posting of Peter R. Orszag, Director of Office of Management and Budget, to White House Blog, *Fiscal Realities*, <http://www.whitehouse.gov/omb/blog/10/03/21/Fiscal-Realities> (Mar. 21, 2010, 3:05PM EST) (protesting that “An SGR fix, however, is not in this bill—so adding its costs to the legislation posits a piece of legislation that doesn't exist.”).

267. *Id.*

268. Douglas Holtz-Eakin, Opinion, *The Real Arithmetic of Health Reform*, N.Y. TIMES, Mar. 20, 2010, <http://www.nytimes.com/2010/03/21/opinion/21holtz-eakin.html>.

269. *Id.*

270. *Id.* CBO acknowledges that these costs have been omitted and identifies them as being “at least \$50 billion.” Letter from CBO, *supra* note 13.

271. Holtz-Eakin, *supra* note 268.

a “key consideration”²⁷² in the very same report which officially projects deficit reduction. 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.” He 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.”²⁷³ CBO points out specifically 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 IPAB may never actually materialize.²⁷⁴ But CBO was instructed to score the bill as given, no matter how unrealistic, and it did so despite raising several objections.

Even this assumes that Congress stands by other revenue-raising provisions, such as the mandate and the Cadillac tax, which might prove politically unpopular²⁷⁵ or even unconstitutional.²⁷⁶ Even certain revenue-raising provisions, like the increase in capital gains taxes,²⁷⁷ could theoretically undermine revenue by deterring certain forms of taxpayer behavior.

The bill could, in theory, find other offsetting cost reductions, particularly if its preventive care measures prove more effective than expected by CBO and other experts.²⁷⁸ Over a longer period of time, perhaps some of the pilot programs in the bill will prove effective. Dr. Atul Gawande suggests that there is reason for hope:

Pick up the Senate health-care bill—yes, all 2,074 pages—and leaf through it. Almost half of it is devoted to programs that would test various ways to curb costs and increase quality. The bill is a hodgepodge. And it should be. . . .

272. Letter from CBO, *supra* note 13.

273. *Id.*

274. *Id.*

275. See WASH. POST, *supra* note 73.

276. See Complaint, State of Florida vs. United States Department of Health and Human Services, *supra* note 53.

277. See *supra* note 78 and text accompanying.

278. Much of the bill is devoted to preventive care measures; unfortunately this Note has not had space to explore them. See, e.g., PPACA, Pub. L. No. 111-148, §§ 4001-4402 (2010). CBO appears to give very little weight to these efforts over the course of a ten-year horizon. See Letter from CBO, *supra* note 13.

Which of these programs will work? We can't know. That's why the Congressional Budget Office doesn't credit any of them with substantial savings. The package relies on taxes and short-term payment cuts to providers in order to pay for subsidies. But, in the end, it contains a test of almost every approach that leading health-care experts have suggested.²⁷⁹

Some programs could prove fruitful, but CBO expresses skepticism. While it 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 particularly that “[t]he imprecision of that calculation reflects the even greater degree of uncertainty that attends to it.”²⁸⁰ And, of course, this is “relative to those [deficits] projected under current law”—that is, it still includes the additional imaginary health expenditure savings associated with Medicare cuts.²⁸¹ All of this analysis assumes, CBO notes dryly, “that all of its provisions continued to be fully implemented.”²⁸²

All told, the bill 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. The implications of this are beyond the scope of this Note, but President Obama and other defenders of the bill should, at a minimum, face those increased deficits squarely in the public debate.

CONCLUSION

Whatever its eventual effects, PPACA does have one virtue: it is well-intentioned. By illegalizing the sort of appalling behavior that the President described, the reform bill communicates a set of social norms

279. See Atul Gawande, *Testing, Testing*, NEW YORKER, Dec. 14, 2009, available at http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande.

280. Letter from CBO, *supra* note 13. GDP in 2009 was \$14.1 trillion. See World Bank, *Gross Domestic Product 2008*, <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GDP.pdf>. If the CBO's estimate refers to 0.25% of the entire decade's worth of GDP (rather than one year's worth of GDP), then it is projecting a floor of \$35.3 billion of savings per year from 2020-2029—about on par with Fortune Magazine's estimate of the cost of the “Doc Fix.” See *supra* text accompanying note 266.

281. Letter from CBO, *supra* note 13.

282. *Id.*

regarding what patients do and do not deserve. In fact, with passage imminent on March 20, the President described the bill as a “patient’s bill of rights on steroids.”²⁸³ If the plan functions as designed, the President’s description will be vaguely accurate: the package is meant to guarantee access to insurance, regardless of a person’s underlying health status. Insurance markets will be forced to treat the sick and the healthy alike as costs shift from actuarially-based models into a social conception of solidarity. The President’s description is a vivid metaphor, one meant to give hope to those locked out of our present insurance system. It gives rights not just to policyholders, but also to anybody who *wishes to become* a policyholder.

Of course, the President did not intend for his description to be taken too literally. But one can imagine that a precise interpretation might be appropriate. Anabolic steroids can provide short-term enhancements in athletic performance, but at the cost of our own underlying dynamism. Eventually, steroids can cripple the system permanently and the body can become dependent on the very source of its ailments.²⁸⁴ Steroids, in other words, provide a temporary benefit at the cost of the system’s long-term health.

Whatever the President actually meant, I fear that history will prove his words all too accurate. He may, contrary to his own intentions, become a prophet.

283. President Barack Obama, Remarks by the President to the House Democratic Congress, (Mar. 20, 2010), *available at* <http://www.whitehouse.gov/the-press-office/remarks-president-house-democratic-congress>.

284. *See generally* Gen Kanayama et al., *Long-Term Psychiatric and Medical Consequences of Anabolic-Androgenic Steroid Abuse*, 98 DRUG & ALCOHOL DEPENDENCE 1, 1.