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FOCUS ON HEALTH CARE REFORM

Trends in the Law: The Patient Protection and Affordable Care Act

Michael Lee, Jr. *

INTRODUCTION

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA),¹ cited by *The New York Times* as “the most expansive social legislation enacted in decades”² and by opponents as “Obamacare.”³ The bill has been subjected to wide-ranging support and criticism, but much of the discussion on both sides has been inaccurate, misleading, and highly partisan.⁴ Between multiple published versions, extensive

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (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. See, e.g., Media Research Center, *The Truth About ObamaCare: What the Liberal Media Aren't Telling You About Obama's Healthcare Plans*, <http://www.obamacaretruth.org> (last visited Dec. 1, 2010).

4. See, e.g., Joan McCarter, *How Insurers Can Game the New System*, DAILY KOS, Apr. 1, 2010, <http://www.dailykos.com/storyonly/2010/4/1/853166/-How-Insurers-Can-Game-the-NewSystem> (listing several incorrect arguments while advocating that the bill be expanded, along with listing several complaints that have nothing to do with the bill); Rachel Weiner, *Palin: Obama's "Death Panel" Could Kill My Down Syndrome Baby*, HUFFINGTON POST, Aug. 8, 2009, http://www.huffingtonpost.com/2009/08/07/palin-obamas-death-panel_n_254399.html; The Market Ticker, <http://market-ticker.org/akcs-www?singlepost=2139125> (Mar. 22, 2010, 13:23 EST) (“[T]his is the end of the health industry in America.”); Media Research Center, *supra* note 3 (displaying a segment titled “Busting Obamacare”); Andrea Santiago, *The Medicus Firm Physician Survey: Health Reform May Lead to Significant Reduction in Physician Workforce*, Jan. 2010, <http://www.themedicusfirm.com/pages/medicus-media-survey-reveals-impact-health-reform> (“What if nearly half of all physicians in America stopped practicing medicine?”). Comments on message boards are too numerous and too vicious to cite, but even CNN's relatively tame message boards are populated with bipartisan vitriol. See CNN Health, *How the Health Care Bill Could Affect You*, <http://www.cnn.com/2010/HEALTH/03/19/interactive.health.care.benefits/index.html>

internal revisions, and a companion bill,⁵ this legislation is highly complex—together the bills total 2,562 pages—and confusing. It has also been subject to wide-ranging popular scrutiny. Under those conditions, it is not surprising that the bill has been so widely misunderstood: it has been criticized inaccurately as promoting government-mandated euthanasia⁶ and a conspiracy to force the government takeover of health care.⁷ It is our hope that the *Yale Journal of Health Policy, Law, and Ethics* can help to fill that gap, serving as legal scholarship's leading examination of this landmark legislation. In doing so, we hope to help satisfy the great curiosity—both global and national—that the bill has sparked.

In order to examine the goals of the bill, it is crucial for readers to understand PPACA's economic foundation. Despite its complexity, PPACA is *not* a hodgepodge of miscellaneous ideas; it is, perhaps surprisingly, a very coherent package. It revolves around one specific provision—the ban on discrimination against preexisting conditions—and each of the other major provisions of the bill is designed to protect that one central feature.

Underlying all of health reform is one fundamental question: what is the purpose of health insurance? Is it meant as an economic and actuarial tool or a social one?⁸ PPACA seeks to push the second answer—to use health insurance to promote socioeconomic solidarity in which the healthy subsidize the sick.⁹ Pure market insurance redistributes costs only on an ex post basis—it stratifies pools based on expected health status, and only shares risk based on unpredictable events. Solidarity insurance, by contrast, does away with this stratification and shares risk even on an ex ante basis.¹⁰ The healthy will always subsidize the unpredictably sick, but market insurance does not ask them to subsidize the *predictably* and chronically ill; solidarity insurance does.

This is not a trivial difference. The United States is a nation in which 75% of all medical expenditures are devoted to chronic illness, which is usually

(including comments such as “Health reform my butt” and “Pelosi needs to see a psychiatrist”).

5. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter HCERA].

6. See Weiner, *supra* note 4.

7. See The Market Ticker, *supra* note 4.

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

9. *Id.*; Frank Pasquale, *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response*, 7 YALE J. HEALTH POL'Y L. & ETHICS 39, 41 (2007) (“Tiering in the health insurance market has already eroded the primary ‘end’ of health insurance: subsidizing the unhealthy, unlucky, and sick with funds from the healthy, lucky, and well.”).

10. For a discussion of ex ante versus ex post distinctions, see Posting of Uwe E. Reinhardt to Economix, <http://economix.blogs.nytimes.com/2010/01/01/is-community-rating-in-health-insurance-fair> (Jan. 1, 2010, 07:01 EST).

predictable.¹¹ The lowest-spending 49% of the population incurs only 3% of medical expenses, and the highest-spending 5% incurs 50% of the expenses.¹² For insurance to thoroughly redistribute that expense gradient, it requires an extraordinary amount of coercion—coercion that the markets, on their own, will not provide.

This is the first and central goal of the PPACA: to prevent health status discrimination. When it takes effect, insurers will no longer be able to charge different rates to the sick; they will no longer be able to exclude certain conditions from coverage; they will no longer be able to stratify premiums and coverage in accordance with actuarial tables. This ban on discrimination based on preexisting conditions is the bill's most famous component.

And yet such legislation, standing on its own, would open up a host of problems. The vast majority of PPACA is thus devoted to solving these created problems. If insurance companies use the healthy to subsidize the sick, then the economically rational response is for the healthy to simply drop coverage entirely.¹³ PPACA thus imposes a mandate—a requirement that every citizen purchase and maintain health insurance or else pay a fine.¹⁴ This solves the problem of dropping coverage, but it creates a new problem: the government can hardly force people to purchase something they cannot afford. And so PPACA thus grants a subsidy.¹⁵ For those Americans who meet certain income qualifications, the government will pay a certain proportion of their health insurance premiums. This, of course, requires money—money that the government raises through a combination of new taxes,¹⁶ Medicare and Medicaid

11. NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, CTRS. FOR DISEASE CONTROL & PREVENTION, *THE POWER OF PREVENTION: CHRONIC DISEASE. . . THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY I* (2009), available at <http://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf>.

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

13. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 26 (2001) ("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*.") (emphasis added).

14. PPACA, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 242-49 (2010), modified by § 10106; amended by HCERA, Pub. L. No. 111-152, § 1002, 124 Stat. 1029, 1032-33 (2010) (to be codified at 42 U.S.C. § 18091, 26 U.S.C. § 5000A).

15. PPACA § 1401, 124 Stat. at 213-20 (to be codified at 26 U.S.C. § 36, 26 U.S.C. § 280C); HCERA § 1001(a)(1)(A), 124 Stat. at 1030-31.

16. See, e.g., PPACA § 1501, 124 Stat. at 242-49, modified by § 10106, amended by HCERA § 1002, 124 Stat. at 1032-33 (to be codified at 42 U.S.C. § 18091, 26 U.S.C. § 5000A) (fines from

cuts,¹⁷ and other financial provisions.¹⁸ These four elements comprise the central provisions of PPACA. Each is devoted to the social solidarity model of health insurance and the economic difficulties that such a model presents, and thus PPACA expands access dramatically. CBO projects that it will reduce America's uninsured by thirty-two million Americans—no small feat.¹⁹

Still, PPACA does not provide universal coverage—some Americans will fall through the cracks. The first piece of our collection, Mark Hall's *Approaching Universal Coverage with Better Safety-Net Programs for the*

the individual mandate); PPACA § 1513(a), 124 Stat. at 253-55, *amended by* HCERA § 1003(b)(2), 124 Stat. at 1033 (to be codified at 49 U.S.C. § 4980H) (fines from the employer mandate); PPACA § 9001, 124 Stat. at 847-53, *amended by* HCERA § 1401, 124 Stat. 1059-60 (to be codified at 26 U.S.C. § 4980I) (excise tax on “Cadillac” plans); PPACA § 9015(a)(1), 124 Stat. at 870-71, *modified by* § 10906, *amended by* HCERA § 1402(b)(2), 124 Stat. at 1063 (to be codified at 26 U.S.C. § 3101) (additional 0.9% payroll tax); HCERA § 1402(a), 124 Stat. at 1060-63 (3.8% investment income tax); PPACA § 9008, 124 Stat. 859-62, *amended by* HCERA § 1404, 124 Stat. at 1064 (to be codified at 26 U.S.C. § 4001) (pharmaceutical industry fees); HCERA § 1405, 124 Stat. at 1064-65 (excise tax on medical devices); PPACA § 10907, 124 Stat. at 1020 (to be codified at 26 U.S.C. § 5000B and note) (indoor tanning tax, nullifying § 9017, a tax on cosmetic medical procedures); PPACA § 6301(e)(2)(A), 124 Stat. at 743-46 (\$2-per-enrollee insurance industry tax); PPACA § 9010, 124 Stat. at 865-68, *modified by* § 10905, *amended by* HCERA § 1406(a)(4), 124 Stat. at 1066 (to be codified at 26 U.S.C. § 4001 note prec.) (insurance industry fees); PPACA §§ 2501-2502, 124 Stat. at 306-10 (to be codified as amended in scattered sections of 42 U.S.C.) (increasing Medicaid reimbursement for prescription drugs).

17. *See, e.g.*, PPACA § 2551, 124 Stat. at 312-15, *modified by* § 10201(f) (to be codified at 42 U.S.C. § 1396r-4(f)) (reducing payments to Disproportionate Share Hospitals); PPACA § 3112, 124 Stat. at 421 (to be codified at 42 U.S.C. § 1395iii) (eliminating the “Medicare Improvement Fund”); PPACA § 3201(b), 124 Stat. at 444 (to be codified at 42 U.S.C. § 1395w-23(c)(6)) (specifying a spending freeze for 2011's Medicare Advantage Program); § 3201(d)(2), 124 Stat. at 445 (to be codified at 42 U.S.C. § 1395w-2(a)(6)(B)) (codifying a more competitive, actuarially-based bidding process for Medicare Advantage); PPACA § 3401, 124 Stat. at 480 (to be codified at 42 U.S.C. § 1395ww(b)(3)(B)) (implementing severe “market basket reductions” to reimbursement scales for providers).

18. *See, e.g.*, PPACA § 3023, 124 Stat. at 399-403, *modified by* § 10308 (to be codified at 42 U.S.C. § 1395cc-4) (a pilot program for payment bundling); PPACA § 10326, 124 Stat. at 961-62 (to be codified at 42 U.S.C. § 1395b-1 note) (a pilot program for pay-for-performance); PPACA § 2702, 124 Stat. at 156 (to be codified at 42 U.S.C. § 300gg-1) (reducing payments to hospitals which report too many hospital acquired conditions); PPACA § 6402(i), 124 Stat. at 760-62 (increasing funding to the Health Care Fraud Abuse and Control Fund); PPACA § 6002, 124 Stat. at 689-96 (to be codified at 42 U.S.C. § 1320a-7h) (mandating disclosure where physicians have some ownership in drug or device manufacturers).

19. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Representative Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010), *available at* <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

Uninsured, explores the populations that will remain uninsured after PPACA's provisions are implemented and the "safety net" options through which they might continue to receive care. PPACA expands funding for such safety net programs—such as Federally Qualified Health Centers (FQHCs)²⁰—but also presents a new challenge for those services. As Professor Hall argues, safety net programs must now also seek to prevent free-riding behavior, lest it undermine solidarity insurance. This element of PPACA—expanding the means and complicating the mission of the safety net—has been highly underappreciated, especially in comparison to the controversy surrounding the constitutionality of the mandate.²¹ And yet for millions of Americans, it will be the only element of health reform that actually impacts their lives. It must not be overlooked.

Perhaps the largest elephant in the room, however, is the question of cost-control. In and of itself, the bill does not impose any surefire ways to control the nation's overall health expenditures.²² Yet the mandate *absolutely* depends upon such control. If costs continue to escalate, then they will place the mandate in danger—and with it, the entire purpose of health reform. In a tentative January estimate, the Congressional Budget Office (CBO) estimated that the bronze family plan, already a low-benefits package, would probably average more than \$12,000²³—approximately double the current national average.²⁴ Plans could rise by \$6,000 a year or more. And this estimate lines up well with the empirical evidence as seen in New York's insurance regulation²⁵ and the evidence regarding our nation's underlying health expense distribution.²⁶ Somehow, CBO's dire predictions have gone underappreciated by observers.

If excess premiums charged to the healthy are higher than the fine associated with the mandate, a rational actor will be motivated to drop coverage and simply

20. PPACA § 5601(a), 124 Stat. at 677; § 10503, 124 Stat. at 1004 (to be codified at 42 U.S.C. § 2546-2).

21. See, e.g., *Florida ex rel. McCollum v. U.S. Dep't of Health and Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fl. 2010) (denying motion to dismiss some counts of a lawsuit filed by the State of Florida and 19 other states challenging the constitutionality of the mandate).

22. For agreement with this assessment, see commentary from Atul Gawande, *Testing, Testing*, NEW YORKER, Dec. 14, 2009, at 34 ("But the legislation has no master plan for dealing with the problem of soaring medical costs.").

23. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Senator Olympia Snowe, U.S. Senate (Jan. 11, 2010), available at http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf.

24. See AMERICA'S HEALTH INSURANCE PLANS, INDIVIDUAL HEALTH INSURANCE 2009 4 (2009), available at <http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf>.

25. AMERICA'S HEALTH INSURANCE PLANS, *supra* note 24, at 5; Anemona Hartocollis, *New York Offers Costly Lessons on Insurance*, N.Y. TIMES, Apr. 17, 2010, at A1.

26. See Stanton, *supra* note 12, at 1.

pay the fine.²⁷ Further, if premiums rise high enough, many families will fall into a built-in “hardship exemption” where the fine will not apply.²⁸ If many of the healthy drop coverage—one of Professor Hall’s concerns, especially if the safety net is robust—premiums will rise further, prompting yet more people to drop their insurance. Premiums will then rise again, sparking what is known as the “adverse selection death spiral” of insurance.²⁹

The bill, therefore, absolutely depends upon controlling medical expenditures. Can it do so? There are no surefire, definitive cost-control mechanisms in the bill, and yet there is some reason for optimism.³⁰

One prominent cost-control attempt is the Independent Payment Advisory Board (IPAB), established to make certain expenditure-reducing recommendations to Congress. Timothy Jost explores the philosophy, politics, and powers of this Board in his piece, *The Independent Medicare Advisory Board*. CBO does not expect much from the Board—CBO projects that it will create only \$15 billion in savings over ten years³¹—but concedes that there is room for wide variation. Professor Jost explores some of the ways in which the IPAB might accomplish its goals.

Nonetheless, it will be a tall order for any one panel, however expert, to resolve America’s health care cost troubles. To that end, it is possible—perhaps likely—that the issue of cost control will have to be revisited. What form might that revisiting take? When might it be necessary, and how strong will it have to be? For that matter, which of PPACA’s broader goals will be accomplished, and at what price?

None of these answers will come easily, but perhaps the most direct guidance will come from the prior Massachusetts health reform. Much of PPACA strongly resembles that state’s Chapter 58 reform from 2006, and so

27. PPACA, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 244-45, *modified by* § 10106 (2010); *amended by* HCERA, Pub. L. No. 111-152, § 1002, 124 Stat. 1029, 1032-33 (to be codified at 26 U.S.C. § 5000A) (establishing the fine as 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). *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).

28. PPACA § 1501(b), 124 Stat. at 246-47 (to be codified at 26 U.S.C. § 5000A) (establishing a hardship exemption if insurance costs more than 8% of a family’s income).

29. For usage of the term, see, for example, Hartocollis, *supra* note 25.

30. *See* Gawande, *supra* note 22, at 34 (“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 But, in the end, it contains a test of almost every approach that leading health-care experts have suggested.”)

31. Letter from Douglas W. Elmendorf to Nancy Pelosi, *supra* note 19, at 6.

Massachusetts can provide an early look at what PPACA's results might be. Stephen Weiner's piece, *Payment Reform After PPACA: Is Massachusetts Leading the Way Again?*, explores the differences and similarities between Massachusetts's reform and the federal reform bill, as well as the successes and failures of Chapter 58. He helps us see which of Massachusetts's results might apply to the nation as a whole, and which were dictated by conditions specific to that state.

Perhaps most prominently, Massachusetts did *not* feel that its Chapter 58 was a complete and comprehensive reform. To the contrary, Massachusetts waited just two years before addressing the cost issue in greater depth with its Chapter 305 legislation. PPACA, like Chapter 58, focuses chiefly on access problems. But, as *Payment Reform After PPACA: Is Massachusetts Leading the Way Again?* explains, Massachusetts did not believe that this was a comprehensive solution to what ails health care today, and so undertook a second aggressive reform just two years later. Even as this issue goes to publication, Massachusetts is considering a third reform. Many of those ideas could be applied to federal health reform, especially if, as CBO projects, costs actually accelerate. The Comment examines the core ideas involved in Chapter 305, assesses their applicability to the federal level, and prepares us for what may perhaps prove to be the second round in the battle over health reform.

PPACA has many laudable intentions and will provide valuable services to many Americans who have previously been underserved. Many of these reforms, however, will not be sustainable if expenditures continue to grow as quickly as they have, much less if they accelerate. If costs continue to spiral, they will derail the mandate and, with it, the rest of PPACA's goals. Perhaps the IPAB will live up to its promise, innovating new payment mechanisms and solving the game theory problem that underlies so much of American health care, or perhaps other provisions of PPACA will prove more important than expected. But it seems more likely that Congress will have to follow the lead of Massachusetts by revisiting the issue of cost control and implementing bold new solutions itself. That option is not politically safe, but it would be safer than the too-alluring alternative of inaction.

