Policy Implications of the Patient Protection and Affordable Care Act

An Exchange Between Don W. King and Prof. Timothy S. Jost***

U.S. Health Care Reform: Comprehensive Insurance or Affordable Care?

*By Don W. King**

In 2010, Congress passed the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).[1] The ACA reflects an approach to health care reform in which insurance[2] is used as the primary means to assure access to care. Under this approach, legislation is designed to increase the percentage of the population who have comprehensive, third-party coverage to pay for the majority of their medical expenses.

Since World War II, Congress and state legislators have often taken this approach, attempting to increase access to care by enacting polices that increase the prevalence of comprehensive, third-party coverage.[3] However, for many years, prices for both health insurance and medical care have increased,[4] and health care expenditures as a percentage of gross domestic product have increased.[5] Economic theory and some data suggest that policies designed to increase comprehensive, third-party coverage may be important contributors to high prices and large expenditures.[6]

This essay recommends a different approach, one in which each individual owns the funds used for his or her health care and chooses both health insurance and medical care from a wide variety of options. To achieve greater individual ownership, Congress and state legislators will need to repeal or decrease present incentives that favor third-party payment over paying directly for both health insurance and medical care. To achieve a wider variety of options, Congress and state legislators will need to repeal or decrease the stringency of many of the regulations presently governing health insurance, professional and hospital care, and pharmaceuticals. In addition, states will need to ensure that liability for medical malpractice does not limit access to care.

The essay is divided into four sections. Section I briefly describes the effects that policies enacted prior to the ACA (pre-ACA) have had on health care prices and expenditures. Section II summarizes the likely effects that major ACA provisions will have on prices and expenditures. Section III outlines an approach to health care reform that would lead to greater individual ownership of health care funds and increase each person's options for health insurance and medical care. Section IV describes how these latter reforms may be more effective than comprehensive insurance at increasing access to care for low-income, high-risk,[7] and older Americans.

I. Effects of Pre-ACA Policies on Prices and Expenditures

When considering the effects that federal and state policies have on health care prices and expenditures, it is important to consider separately the market for health insurance and the market for medical care.

Pre-ACA policies have increased prices for private health insurance in two primary ways. Some policies provide an incentive for individuals to obtain more health insurance than they otherwise would. Other policies restrict one's options for health insurance. Similarly, pre-ACA policies have increased prices for medical care in two primary ways. Some policies provide an incentive for individuals to obtain more medical care than they otherwise would. Other policies effectively restrict one's options for medical care and medical products.

A. Incentive to Obtain Excess Health Insurance

Since 1943, the federal government has allowed an employee to exclude the value of employer-sponsored health insurance (ESI) from gross income when calculating one's income tax.[8] However, the exclusion does not apply if one purchases insurance independent of an employer (IPI), and it does not apply if one pays for medical care directly or "out-of pocket."[9] As a result, there is a strong incentive for individuals to choose ESI over IPI and a strong incentive to choose a comprehensive health plan with minimal cost sharing over a more limited plan that involves significant cost sharing.

By increasing the prevalence of comprehensive, third-party coverage, the exclusion of ESI increases access to care for some people. However, the tax preference for ESI increases the demand for private health insurance,[10] specifically the demand for more expensive, comprehensive insurance with minimal cost sharing. Greater demand for any good or service usually leads to higher prices and larger expenditures.[11] In addition, when an employer owns the funds used for an employee's health insurance, the employee has less ability to choose insurance that best meets the needs of his or her particular situation.[12]

B. Restricted Options for Health Insurance

Beginning in the 1970s, some states enacted laws that restrict health insurance underwriting.[13] For example, some states require insurers to provide insurance to all applicants (*guaranteed issue*), and some states require insurers to charge all applicants the same price (*community rating*), regardless of the insured's risk of incurring medical expenses.[14] In addition, both Congress and states have enacted laws that require insurers to offer or include certain benefits in each insurance policy they sell (*mandated benefits*). For example, Congress has required group health plans to cover at least forty-eight hours of hospital care following childbirth,[15] and some states require insurers to offer or include coverage for items such as in vitro fertilization

**Senior Scholar with the Mercatus Center at George Mason University. Emeritus professor of neurology at the Medical College of Georgia. B.A., Baylor University. M.D., University of Texas Medical Branch. J.D., George Mason University School of Law.*

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or the treatment of alcoholism.[16]

The primary benefit of underwriting restrictions is that high-risk persons are able to purchase health insurance at a lower price than they otherwise would, increasing insurance prevalence among high-risk persons.[17] However, these restrictions increase prices for others,[18] decreasing insurance prevalence among low and average-risk persons.[19] One study suggests that absent a mandate to purchase health insurance, the net effect is a decrease in the overall prevalence of health insurance.[20]

Similarly, the primary benefit of mandated benefits is that persons who need the care for which coverage is mandated will have fewer out-of-pocket expenses than they otherwise would. However, most mandated benefits increase insurance prices,[21] decreasing insurance prevalence among low and average-risk persons.[22] As with underwriting restrictions, one study suggests that benefit mandates decrease the overall prevalence of health insurance.[23] In effect, both underwriting restrictions and mandated benefits prevent people from choosing less expensive insurance that may be better for their particular situation.

C. Incentive to Obtain Excess Medical Care

As noted above, the exclusion from gross income for income tax purposes applies to ESI, but not to funds that a person uses to pay for care directly.[24] As a result, it is in most persons' interest to choose a comprehensive health plan that involves minimal cost sharing. In addition, Congress in 1965 created Medicare and Medicaid, public "insurance" programs that pay for medical care for persons 65 and older and for certain low-income Americans, respectively.[25] Because these programs pay for a large majority of a beneficiary's medical expenses,[26] they create a strong incentive for eligible persons to have the federal or state government pay for their medical care.

Both the ESI exclusion and public insurance increase access to care for some people. However, third-party payment for care increases the demand for care, and greater demand usually results in higher prices and larger expenditures. While greater demand and large expenditures for medical care are not necessarily problems,[27] when a third party pays for most care, there are few constraints on the demand for care, and the greater demand may lead to costly expenditures that have relatively few benefits.[28] In addition, when a public or private health plan owns the funds used for an individual's care, an individual has less flexibility to use the funds in the most appropriate way for his or her clinical situation.[29]

Public insurance has additional disadvantages. Because of low payment rates and other factors, some physicians do not accept public insurance beneficiaries.[30] Also, public insurance requires public funding, and the taxation necessary to fund public insurance has costs to society in addition to the cost of the funds collected.[31] Finally, because public spending for health care now represents a large and growing portion of both federal and state budgets,[32] public insurance in its present form is not likely to be sustainable.[33]

D. Restricted Options for Medical Care and Medical Products

During the latter half of the 20th century, both Congress and state legislators enacted numerous regulations governing professional care, medical facility care, and pharmaceuticals. For example, states began licensing and delineating scope of practice rules for a number of relatively new health professions,[34] and many states established planning boards that require hospitals and other facilities to obtain a certificate of need (CON) before expanding facilities or purchasing major equipment.[35]

In 1962, Congress for the first time required pharmaceutical companies to gain approval from the U.S. Food and Drug Administration (FDA) before releasing a new drug to the U.S. market.[36] In 1996, Congress authorized the Department of Health and Human Services (HHS) to develop regulations related to the privacy and security of personal health information.[37] Finally, beginning around 1960, the number and monetary value of state medical malpractice lawsuits increased.[38]

Both health care regulations and the threat of malpractice liability have benefits. Potential benefits include higher quality care, safer drugs, or greater confidentiality of personal health information. However the benefits of some of these regulations appear to be small. For example, many studies suggest that stringent licensing and scope of practice rules do not increase quality,[39] and many data suggest that nurse practitioners are able to provide high quality primary care and high-quality, low-risk labor and delivery care.[40]

In addition, even beneficial regulations increase the cost of providing care, and some regulations specifically restrict the entry of competitors.[41] For example, studies suggest that stringent licensing rules increase professional wages[42] and increase prices for some types of professional care.[43] In a series of studies in the 1980s, Federal Trade Commission investigators found that CON rules do not decrease hospital costs, but in some cases increase them.[44] Similarly, the development of new pharmaceuticals is costly,[45] and regulatory compliance is likely an important component of total cost.[46] As with health insurance regulations, regulations involving medical care and medical products in effect prevent persons from choosing less expensive options.

Finally, while studies of malpractice law are subject to error, the best available data suggest that a large majority of patients injured by substandard care do not sue.[47] Other studies suggest that when a lawsuit is filed, there is not a strong correlation between substandard care and compensation of victims.[48] If these studies are correct, it is likely that most persons injured by substandard care are not receiving compensation, and malpractice law may not be having a significant deterrent effect.[49] In addition, studies suggest that malpractice law is administratively costly,[50] and the threat of a malpractice lawsuit may lead physicians to use excess resources[51] or discontinue providing certain types of care.[52]

II. ACA Provisions Designed to Increase Third-Party Coverage

The ACA includes a number of provisions designed to extend comprehensive, third-party coverage to a larger percentage of the population. For example, the ACA requires most Americans to purchase health insurance or pay a penalty (individual mandate),[53] provides persons with income between one and four times the federal poverty level (FPL) a tax credit to purchase insurance,[54] requires employers to pay an assessment if one of their employees receives a tax credit,[55] and expands Medicaid to all persons whose income does not exceed 138

percent of the federal poverty level.[56]

In addition, the ACA requires health plans and insurers to cover a standard benefit package,[57] prohibits both health plans and insurers from imposing a preexisting condition exclusion and from establishing rules for eligibility based on health status,[58] requires insurers to issue insurance and guarantee renewability to all employer and individual applicants,[59] and prohibits insurers in the individual and small group markets from varying premiums based on heath status.[60]

The individual mandate, the tax credit to purchase private insurance, and the employer assessment will undoubtedly increase the prevalence of private health insurance and may increase access to care for some people. However, each of these features will increase the demand for private insurance, and the greater demand will likely lead to higher insurance prices and larger expenditures.

Similarly, the individual mandate, tax credit, employer assessment, and Medicaid expansion will increase the overall prevalence of third-party coverage and may increase access to care for some people. However, each of these features will increase the demand for medical care, and the greater demand will likely lead to higher prices and larger expenditures. Also, because many persons may substitute Medicaid for private insurance,[61]and because many physicians do not accept Medicaid beneficiaries,[62] new Medicaid beneficiaries may have less access to care than they had prior to the ACA.

Both the ACA's tax credit and insurance regulations will make health insurance more affordable for some people.[63] However, both the credit and the regulations will increase insurance prices for others.[64] In addition, the insurance regulations will prevent insurers from developing less expensive and more innovative types of insurance for people who desire them.

Finally, the tax credit to purchase private insurance and the expansion of Medicaid will increase federal spending,[65] and the taxation necessary to fund the extra spending will have costs to society in addition to the cost of the funds collected.[66]

III. Alternative Approach to Health Care Reform

As noted in Section I, some federal and state policies provide an incentive for individuals to have a third party pay for their health insurance and medical care. Other policies in effect restrict one's options for either health insurance or medical care. As noted in Section II, the ACA will likely increase the extent of third-party payment for medical care and further restrict one's options for health insurance. Together, these features will likely lead to even higher prices and larger expenditures.

In contrast, reforms that return health care funds to individuals and reforms that allow a wider variety of health insurance and medical care options should lead to both lower prices and fewer expenditures.[67] In addition, by giving individuals more control over their health care dollars, and by allowing insurers, professionals, and pharmaceutical companies to provide a wider variety of services and products, these reforms should lead to more personalized care, greater innovation, and potentially higher quality.

Reforms to achieve greater individual ownership and a wider variety of options can be organized under five categories: (1) repeal ACA provisions that increase third-party coverage;[68] (2) equalize the tax treatment of funds used for health care; (3) replace public insurance with public subsidies and private philanthropy; (4) repeal or decrease restrictions on private health insurance; and (5) repeal or decrease restrictions on medical care and medical products.

A. Repeal ACA Provisions That Increase Third-Party Coverage

To increase individual ownership of health care funds, Congress will need to repeal ACA's individual mandate,[69] employer assessment,[70] and Medicaid expansion.[71] Repealing the individual mandate and employer assessment should prevent a large increase in the demand for private health insurance and a large increase in insurance prices and health care expenditures. Similarly, repealing the individual mandate, employer assessment, and Medicaid expansion should prevent a large increase in the demand for medical care and a large increase in medical care prices and health care expenditures.

To increase one's options for health insurance, Congress will need to repeal ACA's underwriting restrictions[72] and required benefit package.[73] Repeal of both types of requirements should prevent a large increase in insurance prices[74] and allow insurers to provide a wider variety of insurance options.

To prevent a large increase in public expenditures,[75] Congress will need to repeal ACA's tax credit [76] and Medicaid expansion.[77] Finally, repealing each of the provisions described in Section II will be necessary to achieve many of the reforms recommended below.

B. Equalize Tax Treatment of Health Care Funds

To increase individual ownership of health care funds, Congress will need to partially equalize the tax treatment of ESI, IPI, and direct payment for care.[78] For example, Congress could enact a standard tax credit for health insurance,[79] enact a standard deduction for health insurance,[80] or decrease restrictions presently placed on health savings accounts (HSAs).[81]

More equal tax treatment would allow individuals to choose between ESI and IPI, free of the tax code's influence. It also would allow persons to choose between purchasing low deductible, comprehensive plans and high deductible, less comprehensive plans, free of the tax code's influence.[82] Some people would continue to choose ESI and to choose comprehensive plans with minimal cost sharing. Others would choose IPI or pay directly for more of their care. It is likely that over time, individuals would begin to purchase insurance independent of their employer and to pay directly for more of their care. As more individuals use their own funds to purchase health insurance and pay for medical care, prices for health insurance, prices for medical care, and health care expenditures should decline.[83]

Greater individual ownership would have other benefits. If individuals owned their health care funds, insurers would have greater incentive to develop innovative types of insurance, and both professionals and medical facilities would have greater incentive to develop innovative ways to provide cost-effective care. Each of the reforms that partially equalize tax treatment would lead to less federal revenue. However, the lost revenue would be small compared to the lost revenue that presently

results from the exclusion of ESI from gross income.[84]

C. Replace Public Insurance with Subsidies and Philanthropy

Also to increase individual ownership of health care funds, Congress will need to replace public insurance with public subsidies and private philanthropy.[85] For example, Congress or states could replace public insurance with a subsidy that a person could use to purchase insurance or pay directly for care.[86] The subsidy amount could be based on a person's income, one's risk of incurring medical expenses,[87] or both. Private philanthropy could take the form of a contribution to an organization that supports medical care for persons who need assistance or a contribution to a professional organization that provides care for persons who need assistance.[88]

Replacing public insurance with a public subsidy would allow beneficiaries to choose from the same health insurance and medical care options available to non-beneficiaries. Because many physicians do not accept public insurance beneficiaries,[89] replacing public insurance with a public subsidy may improve access to care, especially among Medicaid beneficiaries. Also, if individual beneficiaries owned their health care funds, insurers would have an incentive to develop innovative and less expensive insurance, and professionals and hospitals would have an incentive to develop more innovative ways to provide cost-effective care.

In addition, replacing public insurance with a subsidy of a defined amount would allow both the federal and state governments to better control their expenditures.[90] Finally, because private philanthropy tends to be more flexible and more adaptable to the needs of each person than either public insurance or public subsidies, and because it does not entail taxation costs,[91] private philanthropy offers the possibility of even greater access to care at less cost to society.

One potential disadvantage of a subsidy for low-income persons is that some persons may not seek the care they need.[92] While most beneficiaries should be able to manage their health care funds wisely,[93] it may be necessary to require some beneficiaries to purchase a comprehensive health plan or to provide a subsidy at the point of care.[94]

D. Decrease Restrictions on Private Health Insurance

To increase one's options for health insurance, Congress and state legislators will need to repeal or decrease the stringency of many of the underwriting restrictions and mandated benefits presently governing health insurance. For example, states could repeal present requirements for community rating or requirements for insurers to pay for the treatment of alcoholism.[95] Congress could repeal the requirement that health plans that provide mental health benefits provide the same annual and lifetime limits for mental health benefits as for medical/surgical benefits.[96] Similarly, using its authority to regulate interstate commerce, Congress could exempt an insurer in one state from underwriting restrictions and benefit mandates imposed by a purchaser's state.[97]

Each of these reforms should lead to both lower health insurance premiums and greater insurance prevalence.[98] In addition, these reforms would allow insurers to design more innovative types of insurance and allow individuals to choose insurance more suited to their particular needs. The primary disadvantage is that high-risk persons and persons who require care for which payment is presently mandated would be required to pay higher premiums or incur more out-of-pocket expenses. However, there are a number of ways Congress and state legislators can facilitate greater high-risk access that do not significantly increase insurance prices for others.[99]

E. Decrease Restrictions on Medical Care and Medical Products

To increase one's options for medical care and medical products, Congress and states will need to repeal or decrease the stringency of many of the regulations presently governing professional care, medical facility care, and pharmaceuticals. For example, states could repeal or decrease the stringency of their scope of practice rules for mid-level practitioners,[100] or states could repeal their CON laws for facility expansion.[101] To increase access to new pharmaceuticals, Congress could allow private drug-certifying bodies to carry out many of the functions presently performed by the FDA,[102] allow a dual track option for access to experimental drugs,[103] maintain the requirement for safety and efficacy, but eliminate the requirement for prior approval,[104] or maintain the requirement for safety, but eliminate the requirement that pharmaceutical manufacturers demonstrate efficacy before releasing a new drug.[105]

Also to increase one's options for medical care, states that have not done so will need to reform their medical malpractice law.[106] For example, states could place a cap on non-economic damage awards[107] or enforce patient-physician contracts for malpractice protection made in advance of care.[108]

Fewer restrictions on professionals, facilities, and pharmaceutical companies should decrease the cost of providing care and should lead to lower prices. In addition, these reforms would allow professionals and hospitals to develop more innovative ways to provide care.[109] Similarly, liberalizing the rules governing new drug development may allow pharmaceutical companies to develop new drugs that cannot be cost-effectively developed under the present regulatory framework. Finally, meaningful medical malpractice reform should result in both lower prices and more readily available care.[110]

Potential disadvantages of fewer restrictions include less patient safety or less patient privacy. However, as noted previously, data suggest that many of these regulations have relatively few benefits, but often large costs. Each regulation should be evaluated, and those for which costs outweigh benefits should be eliminated or made less stringent.

IV. Effects of Reforms on Persons Who May Need Assistance

Reforms that facilitate individual ownership of health care funds and reforms that increase one's options for health insurance and medical care should lead to lower prices, and thus greater access to care for most people. However, even with lower prices, some people may need assistance in paying for care. This section discusses how the recommended reforms should improve access for low-income, high-risk, and older Americans.[111]

A. Low-Income Persons

Each of the recommended reforms should result in lower prices for either health insurance, medical care, or both. Lower

prices would be especially beneficial for low-income persons. While a standard deduction and less restrictive HSAs would have less direct benefit for a low-income person,[112] either reform would allow low-income persons on the margin to better afford both health insurance and medical care, and either would increase the ability of higher-income persons to contribute to low-income care. Unlike a standard deduction, a standard tax credit for health insurance would provide an equal benefit for low-income and high-income persons.[113] If the credit were made refundable, it could serve as a subsidy for low-income persons, significantly increasing their insurance prevalence.

Three reforms may be especially beneficial. Most people do not benefit from underwriting restrictions and required benefits. Eliminating or decreasing these requirements would allow many low-income persons to purchase less expensive insurance that covers large, unexpected expenses. Similarly, fewer restrictions on mid-level practitioner care should increase low-income access to primary and low-risk labor and delivery care.[114] Finally, allowing patients and physicians to contract for malpractice protection in advance of care may encourage more physicians to provide low-income care at either no charge or a discounted rate.[115]

For low-income individuals who do need assistance, a public subsidy or private philanthropy should provide greater access than public insurance.[116] A subsidy in advance of care would allow a recipient to choose insurance and care from the same options available to others.[117] Because private, philanthropic support is more adaptable to the needs of each individual, and because it does not entail taxation costs,[118] private philanthropy offers the possibility of even greater low-income access at less cost to society.[119]

B. High-Risk Persons

As noted previously, each of the recommended reforms should result in lower prices for either health insurance, medical care, or both. Because high-risk persons often require more care and because their insurance may be more expensive, lower prices would be especially beneficial for them. Also, high-risk persons are not necessarily low-income. Equalizing the tax treatment of ESI, IPI, and direct payment would make it possible for more high-risk persons to pay for their own care and more high-income persons to contribute to organizations that support high-risk care.

Three reforms may be especially beneficial. Many high-risk individuals do not benefit from health insurance mandates. Fewer mandates would allow these persons to obtain health insurance at lower prices. Also, high-risk persons often require care from specialized facilities.[120] Eliminating or decreasing the extent of CON laws should facilitate the development of additional specialized centers, potentially increasing high-risk access to specialized care. Finally, fewer restrictions on access to new pharmaceuticals would be especially advantageous for high-risk persons who face life-threatening illnesses.[121]

While many high-risk persons may be able to obtain affordable insurance in an unregulated market,[122] some will likely require assistance. For those who do, a public subsidy or private philanthropy is more likely than underwriting restrictions to increase access, without increasing prices for others. A subsidy could be provided to a state-created high-risk pool,[123] or a risk-adjusted subsidy could be provided directly to a high-risk individual to purchase private insurance or pay directly for care. As with low-income persons, private philanthropy offers the possibility of even greater high-risk access at less cost to society.

C. Medicare Beneficiaries

Each of the recommended reforms should result in lower prices for either health insurance or medical care. Similar to high-risk persons, older persons tend to require more care, and as a result, lower prices would be especially beneficial for them.

Congress also should consider replacing traditional Medicare with a subsidy that a beneficiary could use to purchase private insurance or pay directly for care.[124] A subsidy could be income based, risk adjusted, or both. The primary advantage of a subsidy over Medicare insurance is that a beneficiary would be able to choose from health insurance and medical care options similar to those available to younger people. Also, if beneficiaries owned the funds used for their care, insurers would have an incentive to develop innovative types of insurance for seniors, and professionals and facilities would have an incentive to develop more cost-effective ways to provide senior care. Replacing Medicare "insurance" with a subsidy of a defined amount also would allow the federal government to better control both its present expenditures and long term liabilities.[125]

Finally, Congress should consider allowing younger Americans to opt out of Medicare, placing their Medicare payroll taxes and other contributions into personal accounts to pay for retirement medical expenses.[126] By converting Medicare payroll taxes into savings for health care, it is possible that over time, both Medicare as an insurance program and public subsidies could be eliminated.[127] Low-income and high-risk seniors could be eligible for the same public subsidies and private philanthropy described earlier for other low-income and high-risk individuals.

V. Summary

During the 20th century, both the federal and state governments enacted laws that led to third parties paying for most U.S. health insurance and third parties paying for most U.S. medical care. Both also enacted laws that placed restrictions on the types of health insurance that insurers can offer and the ways that professional and hospitals can provide care. In addition, the federal government required pharmaceutical companies to gain approval before releasing a new drug to the U.S. market, and the number and value of medical malpractice lawsuits increased. While each of these developments has had benefits, together they have contributed to high prices for health insurance, high prices for medical care, and large health care expenditures.

To decrease prices for both health insurance and medical care, Congress and state legislators will need to repeal or decrease the effects of laws that favor third-party payment

over paying directly for both health insurance and medical care and to repeal or decrease the stringency of many of the regulations presently governing health insurance and medical care. In addition, the federal government will need to decrease restrictions on access to new pharmaceuticals, and states will need to enact reforms to assure that malpractice lawsuits do not limit access to care.

By making insurance and care more affordable, greater individual ownership of funds and a wider variety of options should increase access to care for most people. In addition, these reforms should lead to fewer excess expenditures, greater innovation, and potentially higher quality. Finally, these reforms may be more effective than universal, comprehensive insurance at increasing access to care for low-income, high-risk, and older Americans.

Endnotes

1 Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010). The ACA was amended by the Health Care and Education Reconciliation Act of 2010. Pub. L. 111-152, 124 Stat. 1029 (2010).

2 For health insurance to efficiently spread the risk of loss, the loss must be uncertain, measurable, and large. In addition, insurance premiums must be based on the insured's risk, and the risk pool must consist of a large number of insured. *See* John A. Boni et al., The Health Insurance Primer: An Introduction to How Health Insurance Works 3 (2000). Today, most U.S. health insurance contains a component of true insurance, as well as a large component of "prepaid benefits" that cover small, expected expenses. In addition, self-insured employee benefit plans and public programs pay for medical care for many Americans. For this paper, "health insurance" refers to the various forms of payment for medical care that include a component of true insurance.

3 Section 1 briefly describes these attempts.

4 Between 1988 and 2007, premiums for employer-sponsored insurance increased at a greater rate than the Consumer Price Index (CPI). *See* The Kaiser Family Found. et al., Employer Health Benefits: 2007 Annual Survey, Exhibit 1.1: Average Percentage Increase in Health Insurance Premiums Compared to Other Indicators, The Henry J. Kaiser Family Found. 19 (2007), *available at* http://www.kff.org/insurance/7672/upload/76723.pdf. Similarly, between 1960 and 2009, prices for medical care increased at a greater rate than the CPI (author's calculation). Databases, Tables, and Calculators by Subject, All Urban Consumers (Current Series), Bureau of Lab. Stat., http://www.bls.gov/data/.

5 *See* Table I, National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2009, Centers for Medicare and Medicaid Services, http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

6 Section 1 of this essay describes the effects that federal and state policies, including policies designed to increase third-party coverage, have had on health care prices and expenditures.

7 For this essay, a high-risk person is one who because of a genetic variation, chronic disease, or other condition is more likely to incur large medical expenses than other persons.

8 26 U.S.C. § 106(a) (2006); *see also* Tom Miller, How the Tax Exclusion Shaped Today's Private Health Insurance Market, Joint Economic Committee (Dec. 2003), *available at* http://www.aei.org/docLib/20070222_Millerarticle.pdf.

9 More recently, Congress has enacted additional tax preferences that allow some people to pay directly for care with tax-free funds. These include flexible spending accounts (26 U.S.C. § 125); health reimbursement arrangements (*see* I.R.S. Notice 2002 – 45, *available at* www.irs.gov/pub/irs-drop/n-02-45.pdf; I.R.S. Bulletin 2002 – 28 I.R.B., (July 15,2002), *available at* www.irs.gov/pub/irs-irbs/irb02-28.pdf; and health savings accounts (HSAs) (26 U.S.C. § 223). HSAs will be discussed further in Section 3.

10 The tax preference for ESI increases the demand for private health insurance in at least three ways. First, the exclusion makes health insurance, which is paid with pre-tax dollars, less costly to an employee than an employee's other expenses, which are paid with post-tax dollars. Second, because an employer pays for the insurance, the cost is "hidden" from the employee. Third, because the exclusion does not apply to funds used to pay for care directly, the employee has an incentive to obtain a more costly comprehensive health plan with minimal cost-sharing.

11 In a 1973 study, Martin Feldstein showed that under the conditions present at that time, hospital prices and the demand for health insurance were mutually reinforcing, (i.e., an increase in the price of hospital care resulted in an increase in the demand for health insurance, and vice versa). He also showed that greater average coinsurance rates would result in substantial welfare gains. *See* Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance,* 81 J. Pol. Econ. 251, 261–265, 275–277 (1973).

12 To take advantage of the ESI exclusion, an employee must choose from the plans offered by one's employer, and many employers are able to offer only one or a limited number of plans.

13 Insurance underwriting is the process of determining the risk of an applicant, whether to offer insurance, and the price to be charged.

14 *See* Merrill Mathews, Victoria C Bunce, & J. P. Wieske, State Health Insurance Index 2006: Methodology 1 (2006), *available at* http://www.cahi.org/cahi_contents/resources/pdf/StateIndexMethodology.pdf.

15 Pub. L. No. 104-204; 29 U.S.C. § 1185(a).

16 *See* Victoria C. Bunce & J.P. Wieske, Health Insurance Mandates in the States 2010, Council for Affordable Health Insurance 1, 3 (2010), *available at* http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf.

17 *See, e.g.,* Amy Davidoff, Linda Blumberg, & Len Nichols, *State Health Insurance Market Reforms and Access to Insurance for High-Risk Employees*, 24 J. Health Econ. 725 (2005).

18 *See* Amanda E. Kowalski, William J. Congdon, and Mark H. Showalter, *State Health Insurance Regulations and the Price of High-Deductible Policies,* 11(2) Forum for Health Econ. and Pol. 1, 10–12 (2008).

19 *See, e.g.*, Bradley Herring & Mark V. Pauly, *The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market* 19 (Nat'l Bureau of Econ. Research, Working Paper No. 12504, 2006), *available at* http://www.nber.org/papers/w12504.pdf.

20 *Id.* at 19.

21 *See, e.g.*, Michael J. New, The Effect of State Regulations on Health Insurance Premiums: A Revised Analysis, The Heritage Foundation 5 (2006).

22 *See, e.g.,* Frank A. Sloan & Christopher J. Conover, *Effects of State Reforms on Health Insurance Coverage of Adults,* 35 Inquiry 280, 288 (1998).

23 *Id.*

24 26 U.S.C. § 106(a) (2006); *see also* Miller, *supra* note 8.

25 Social Security Amendment of 1965, Pub. L. 89-97, 79 Stat. 286 (1965).

26 Medicare does have cost-sharing features, but traditional Medicaid does not.

27 Much of the increased health care spending over the past 40 years has likely had significant health benefits. *See, e.g.*, David M. Cutler & Mark McClellan, *Is Technological Change Worth It?* 20(5) Health Aff. 11 (Sept./Oct. 2001); *see also* Frank R. Lichtenberg, *Sources of U.S. Longevity Increase, 1960-1997* (Nat. Bureau Econ. Res., Working Paper No. 8755, 2002).

28 Many studies suggest that at least a portion of health care spending does not improve health outcomes. *See, e.g.*, Jonathan Skinner, Elliott S. Fisher & John E. Wennberg, *The Efficiency of Medicare*, (Nat'l Bureau of Econ. Research, Working Paper No. 8395, 2001); Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care,* 138 Ann. Intern. Med. 288 (2003); *see also* Willard G. Manning, et al., *Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment,* 77 Am. Econ. Rev. 251 (1987).

29 For example, a person's health plan may pay for care a beneficiary does not need, but not pay for care a beneficiary does need.

30 *See* Peter Cunningham & Jessica May, Medicaid Patients Increasingly Concentrated Among Physicians, Tracking Report No. 16, Center for Studying Health System Change 1 (Aug., 2006), *available at* http://www.hschange.com/CONTENT/866/866.pdf.

31 Social welfare costs that result from taxation include the taxpayer cost for the Internal Revenue Service to develop rules governing taxation and to collect taxes and the cost for taxpayers to comply with the tax code. *See, e.g.*, J. Scott Moody, Andy P. Warcholik & Scott A. Hodge, The Rising Cost of Complying with the Federal Income Tax, Special Report No. 138, Tax Foundation (Dec. 2005), *available at* www.taxfoundation.org/files/sb_amicus_fiavstaxcommwv.pdf. There are also the deadweight losses resulting from the tax code's incentives for inefficient behavior. *See e.g.*, Martin A Feldstein, *The Effect of Taxes on Efficiency and Growth*, (Nat'l Bureau of Econ. Research, Working Paper No. 12201, 2006).

32 *See* Barbara S. Klees, Christian J. Wolfe, & Catherine A. Curtis, Brief Summaries of Medicare & Medicaid Title XVII and Title XIX of the Social Security Act 21 (2010), *available at* http://www.cms.gov/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2010.pdf.

33 *See, e.g.*, The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 4 (2009), *available at* http://www.cms.hhs.gov/reportstrustfunds/downloads/tr2009.pdf.

34 *See, e.g.*, Gary L. Gaumer, *Regulating Health Professionals: A Review of the Empirical Literature,* 62 Milbank Memorial Fund Q., Health & Soc'y 380 (1984).

35 *See* Patrick J. McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System,* 23 Fl. St. U. L. Rev. 141, 147 (1995).

36 To obtain approval, a pharmaceutical company must demonstrate that a new pharmaceutical is both safe and effective for at least one condition. *See* Drug Amendments of 1962, Pub. L. No. 87-781.

37 *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

38 *See* Paul C. Weiler, Medical Malpractice on Trial, 1–16 (Harvard University Press, 1991).

39 *See e.g.*, Deborah Haas-Wilson, *The Effect of Commercial Practice Restrictions: The Case of Optometry,* 29 J.L. & Econ. 165, 183 (1986).

40 *See, e.g.*, Sue Horrocks, Elizabeth Anderson, & Chris Salisbury, *Systemic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors,* 324 Brit. Med. J.819, 821 (2002); Judith Rooks et al., *Outcomes of Care in Birth Centers: The National Birth Center Study,* 321 New Eng. J. Med. 1804 (1989).

41 Higher costs and fewer competitors decrease the supply of care, and a smaller supply usually leads to higher prices.

42 *See, e.g.*, William D. White, *The Impact of Occupational Licensure of Clinical Laboratory Personnel*, 13 J. Hum. Res. 91, 101 (1978); Frank A. Sloan & Bruce Steinwald, Hospital Labor Markets 46 (1980).

43 *See, e.g.*, Lawrence Shepard, *Licensing Restrictions and the Cost of Dental Care,* 21 J.L. & Econ. 187, 189 (1978); Deborah Haas-Wilson, *The Effect of Commercial Practice Restrictions: The Case of Optometry,* 29 J.L. & Econ. 165, 183 (1986).

44 *See, e.g.*, Keith B. Anderson & David J. Kass, Certificate of Need Regulation of Entry into Home Health Care, Bureau of Economics Staff Report to the Federal Trade Commission 92 (1986); Daniel Sherman, The Effect of State Certificate-of-Need Laws on Hospital Costs, Bureau of Economics Staff Report to the Federal Trade Commission (1988).

45 *See* Joseph A. Dimasi, Ronald W. Hansen, & Henry G. Grabowski, *The Price of Innovation: New Estimates of Drug Development Costs,* 22 J. Health Econ. 151, 180 (2003) (estimating that the capitalized research and development cost for each new drug approved was $802 million); Christopher P. Adams & Van V. Brantner, *Estimating the Cost of New Drug Development: Is It Really $802 million?*, 25 Health Affairs 420, 427 (2006) (finding that a research and development cost of $802 million may be an underestimate).

46 *See, e.g.,* Adams & Brantner, *supra* note 45, at 426–27.

47 For example, in two controlled studies, less than 3% of patients injured by substandard care brought suit, *See* A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III*, 325 New Eng. J. Med. 245, 247 (1991); David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado,* 38 Med. Care 250, 254–55 (2000).

48 *See e.g.*, T.A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcome of Medical-Malpractice Litigation*, 335 New Eng. J. Med. 1963, 1965 (1996); David Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 New Eng. J. Med. 2024, 2029 (2006).

49 Investigators with the Harvard Medical Practice Study attempted to determine whether state malpractice law was having a deterrent effect on medical injuries. They found a trend suggesting that patients cared for by physicians who faced greater malpractice risk had fewer injuries from substandard care, but the results were not statistically significant. *See* Paul C. Weiler et al., A Measure of Malpractice, Ch. 6 (1993).

50 *See, e.g.*, Towers Perrin, 2009 Update on U.S. Tort Cost Trends 1, 10 (2009), *available at* http://www.towersperrin.com/tp/getwebcachedoc?webc=USA/2009/200912/2009_tort_trend_report_12-8_09.pdf.

51 *See* Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. Econ. 353, 383 (1996); Daniel Kessler & Mark McClellan, *Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care,* 84 J. Pub. Econ. 175, 178 (2002).

52 *See* Daniel P. Kessler, William M. Sage, & David J. Becker, *Impact of Malpractice Reforms on the Supply of Physician Services,* 293 JAMA 2618, 2620–621 (2005).

53 Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1501(b) (2010). The Supreme Court recently ruled that the individual mandate was unconstitutional as a regulation under the Commerce Clause and the Necessary and Proper Clause, but that the penalty for not purchasing health insurance was constitutional as a tax. *See* National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566, 2590–2591, 2593, 2599–2560 (2012).

54 The credit is available to eligible persons who purchase insurance through an ACA-authorized state-created exchange. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1401(a) (2010); Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, § 1001(a) (2010).

55 Pub. L. No. 111-148, § 1513(a), 124 Stat. 119 (2010).

56 Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119 (2010); Pub. L. 111-152, § 1004(e). The Supreme Court recently ruled that if states choose not to expand Medicaid, the federal government cannot withhold federal funds that states use to pay for their pre-ACA Medicaid program. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2604-2607 (2012).

57 Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 §§ 1302(a)-(b) (2010).

58 Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1201 (2010). *Id.*

59 *Id.*

60 *Id.*

61 A number of studies have shown that when eligibility for public insurance is expanded, many privately insured patients substitute public insurance for private insurance. *See, e.g.*, David M. Cutler & Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?* 111 Quart. J. Econ. 391 (1996); Jonathan Gruber & Kosali Simon, *Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* 27 J. Health Econ. 201,209–213, 216 (2008).

62 *See* Cunningham & May, *supra* note 30.

63 ACA's tax credit will make private insurance more affordable for certain low and middle income persons, and ACA's insurance regulations will make insurance more affordable for certain high-risk persons.

64 The Congressional Budget Office (CBO) estimated that the ACA will increase 2016 insurance premiums in the individual market by 10 to 13 percent over what they otherwise would be. *See* Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Honorable Evan Bayh (Nov. 30, 2009), *available at* http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

65 The Centers for Medicare and Medicaid Services Office of the Actuary estimated that from 2014 through 2019, the ACA will increase federal spending for premium and cost-sharing subsidies by $507 billion and for Medicaid and S-CHIP expansion by $410 billion. Under the ACA, subsidies to purchase private insurance will begin in 2014, increase annually from 2014 through 2019, and continue to increase annually after 2019. *See* Memorandum from Richard S. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs. Office of the Actuary, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended 4–5, tbl. 1 (Apr. 22, 2010), http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

66 *See* discussion and references cited, *supra* note 31.

67 Many data suggest that when persons use their own funds and pay directly for care, both prices and expenditures decline. For example, most people pay directly for cosmetic surgery and LASIK surgery. While inflation-adjusted prices for health insurance and most medical care have increased during the past fifteen years, inflation-adjusted prices for both cosmetic surgery and LASIK surgery have decreased. *See* Devon M. Herrick, *Health Care Entrepreneurs: The Changing Nature of Providers*, Nat'l Ctr. of Pol'y Analysis, Pol'y Rep. No. 318, Dec. 2008. Similarly, centers that cater to individuals who pay directly, e.g., "medical tourist" destinations both in foreign countries and in the United States, charge considerably less for the same procedures than do most U.S. medical centers. *Id.* Finally, most Singaporeans own the funds used for their care and pay directly for most care. *See* Rob Taylor & Simon Blair, Financing Health Care: Singapore's Innovative Approach, The World Bank Group, Note No. 261, (May 2003), http://rru.worldbank.org/documents/publicpolicyjournal/261Taylo-050803.pdf. In 2005, health care expenditures in Singapore were $944 dollars per capita (3.5% of GDP), much lower than in any other advanced country. World Health Org., World Health Statistics 2008 88 (2008), *available at* http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf. In addition, while comparison studies of health outcomes in persons with specific diseases are not available, Singapore's neonatal mortality rates are among the lowest in the world, and life expectancy rates are among the highest. *Id.* at 42.

68 The ACA is a complex statute that includes many provisions not discussed in this essay. While this author supports repeal of the entire statute, the recommendations in this section are limited to provisions discussed in Section 2.

69 Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1501(b) (2010).

70 Pub. L. No. 111-148, § 1513(a), 124 Stat. 119 (2010).

71 Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119 (2010); Pub. L. No. 111-152, § 1004(e).

72 Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1201 (2010).

73 *Id.*

74 *See* discussion and references cited, *supra* note 64.

75 *See* discussion and references cited, *supra* note 65.

76 Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1401(a) (2010); Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, § 1001(a) (2010).

77 Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119 (2010); Pub. L. 111-152, § 1004(e).

78 The only way to completely equalize tax treatment would be to repeal the tax preference for ESI and all other preferences for health care. However, because most Americans under age 65 take advantage of the preference for ESI, it is unlikely that Congress would consider repeal without providing other preferences. The recommendations included in this paper partially equalize the tax treatment of funds used for health care, decreasing, but not eliminating, the economic distortions introduced by the preference for ESI.

79 *See e.g.*, Sue A Blevins, Restoring Health Freedom: The Case for a Universal Tax Credit for Health Insurance, Cato Inst., Pol'y Analysis No. 290, Dec. 12, 1997, at 18–20.

80 *See, e.g.*, Office of the Press Secretary, The White House, George W. Bush, *Fact Sheet: Making Private Health Insurance More Affordable for Low-Income Americans* (Feb. 23, 2007), *available at* http://georgewbush-whitehouse.archives.gov/news/releases/2007/02/print/20070223-4.html.

81 HSAs, established by Congress in 2003, allow individuals who meet certain criteria to pay out-of-pocket expenses with pre-tax dollars. Pub. L. No. 108-73; 26 U.S.C.§ 223. However, HSAs are presently subject to annual contribution limits, HSA owners cannot purchase their primary health insurance using HSA funds, and HSA owners must purchase a high-deductible health plan. For a discussion that includes eliminating many of these restrictions, see Michael F. Cannon, Large Health Savings Accounts: A Step Toward Tax Neutrality for Health Care, 11(2) Forum for Health Econ. & Pol'y, Art. 3, pp. 1–27 (2008).

82 As noted earlier, for health insurance to efficiently spread the risk of loss, losses must be uncertain and large. Thus, insurance is most efficient when people purchase insurance for large, unexpected expenses and pay directly for small or expected expenses. *See* discussion and reference cited, *supra* note 2.

83 *See* discussion and references cited, *supra* note 67.

84 The Joint Committee on Taxation estimated that in 2010, the lost federal revenue associated with the exclusion of employer contributions for health care, including insurance premiums, was $105.7 billion. The lost revenue associated with HSA contributions was $0.9 billion. *See* Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2010-2014,* 47–48 (Dec. 15, 2010), *available at* http://www.jct.gov/publications.html?func=startdown&id=3718.

85 Since the nineteenth century, private philanthropy, *see, e.g.,* Paul Starr, The Social Transformation of American Medicine, Book 1, Ch. 4, (1982), and mutual aid, *see, e.g.,* David T. Beito, From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967, Ch. 6, 9, & 10, (2000), have played an important role in providing medical care for Americans who need assistance. While the federal and state governments cannot provide philanthropy, they could facilitate it by repealing or decreasing the effects of laws that may inhibit private philanthropy. For example, there are data suggesting that public provision of social services "crowds out" private contributions to social services. *See, e.g.*, Daniel M. Hungerman, *Are Church and State Substitutes? Evidence from the 1996 Welfare Reform*, 89 J. Pub. Econ. 2245 (2005); Jonathan Gruber & Daniel M. Hungerman, *Faith-Based Charity and Crowd-Out During the Great Depression,* 91 J. Pub. Econ. 1043 (2007). Also, the threat of a malpractice lawsuit may prevent some physicians from providing discounted care to low-income persons. Finally, high tax rates decrease personal wealth that individuals would otherwise be able to contribute to those who need assistance. As a result, decreasing public assistance for health care, reforming medical malpractice law (see below), and decreasing marginal income tax rates may significantly increase philanthropic support for care.

86 The federal government presently matches funds that a state allocates for its Medicaid programs. As a result, states have an incentive to spend more on their programs than they otherwise would. To eliminate this incentive, Congress could replace the jointly-funded Medicaid program with a block grant and allow states the flexibility to replace their present Medicaid programs with subsidies provided to individual recipients.

87 For a discussion of risk adjustment, see Robert Kuttner, *The Risk-Adjustment Debate,* 339 New Engl. J. Med. 1952 (1998).

88 For example, the National Association of Free Clinics estimates that free clinics provide up to $3 billion of care annually for low-income patients. *See* Letter from Bonnie A. Beavers, Exec. Dir., Nat'l Assoc. of Free Clinics, to Members of the Citizens Health Care Working Group (Aug. 28, 2006), *available at* http://govinfo.library.unt.edu/chc/recommendations/orgs/nafc.pdf; *see also* Mohan M. Nadkarni & John T. Philbrick, *Free Clinics: A National Survey,* 330 Am. J. Med. Sci. 25 (2005). In addition, many professionals and hospitals provide care for low-income persons at no charge or at a discounted rate.

89 *See, e.g.*, Cunningham & May, *supra* note 30.

90 A public subsidy of a defined amount would have fewer administrative costs than public insurance and would not be open-ended as is traditional Medicare and Medicaid.

91 *See* discussion and references cited, *supra* note 31.

92 One randomized, controlled study found that low-income persons with certain health conditions who had a high co-insurance rate, and thus had to pay with their own funds for a portion of their care, had poorer health outcomes than did low-income persons who were not required to make co-insurance payments. *See* Manning, et al., *supra* note 28.

93 *See, e.g.*, Leslie Foster, Randall Brown, Barbara Phillips, et al., *Improving the Quality of Medicaid Personal Assistance through Consumer Direction*, Health Affairs W3-163 (Mar. 26, 2003).

94 One way Singapore subsidizes medical care for low-income persons is by providing the subsidy at the time care is provided. *See* Taylor & Blair, *supra* note 67.

95 *See, e.g.*, Matthews et al., *supra* note 14.

96 29 U.S.C. § 1185a (a) (2009).

97 *See e.g.*, Health Care Choice Act of 2007, H.R. 4460, 110th Cong. § 1–4 (2007).

98 *See* Kowalski, et al., *supra* note 18; New, *supra* note 21; Herring and Pauly, *supra* note 19; Sloan and Conover, *supra* note 22.

99 Section 4 describes how the recommended reforms should increase access to care for high-risk persons.

100 *See, e.g.*, Julie A Fairman, John W. Rowe, Susan Hassmiller, et al., *Broadening the Scope of Nursing Practice,* 364(3) N. Engl. J. Med. 193 (Jan. 20, 2011).

101 *See*, *e.g.*, Department of Justice and Federal Trade Commission, Competition in Health Care and Certificates of Need, Joint Statement Before the Illinois Task Force on Health Planning Reform (Sept. 15, 2008), *available at* http://www.justice.gov/atr/public/press_releases/2008/237153a.pdf.

102 *See* Henry I. Miller, To America's Health: A Proposal to Reform the Food and Drug Administration Ch. 5 (2000).

103 *See* Bartley J. Madden, *A Dual Track System To Give More-Rapid Access to New Drugs: Applying a Systems Mindset to the U.S. Food and Drug Administration (FDA)*, 72 Med. Hypotheses 116, 116 (2009).

104 The FDA used monitoring and removal of harmful drugs successfully prior to the 1962 requirement of prior approval. *See* Miller, *supra* note 102, at Ch. 1.

105 *See* Daniel B. Klein & Alexander Tabarrok, *Who Certifies Off-Label?*, 27 Regulation 60, 63 (2004).

106 Federal proposals for substantive reform of malpractice law are likely unconstitutional and are not recommended. *See* Michael I. Krauss & Robert A. Levy, Can Tort Reform and Federalism Coexist?, Pol'y Analysis No. 514 (Cato Institute, Washington, D.C.), 1 (Apr. 2004).

107 For a review of the effects of caps on damage awards, see Michelle M. Mello, Robert Wood Johnson Foundation, Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms, Synthesis Project Report No.10 at 24 (May 2006).

108 For a review of the use of pre-care contacts between patients and physicians, see generally Don W. King, *Contract as a Means of Medical Malpractice Reform*, Pol'y Resource No. 4 (Mercatus Center/George Mason University, Arlington, Va.), Mar. 2007.

109 For example, liberalizing scope of practice rules for nurse practitioners would allow professional groups to better use their professional resources, and repeal of CON laws would allow hospitals to more easily purchase equipment for expansion of existing programs or development of new programs.

110 *See, e.g.*, Towers Perrin, *supra* note 50; Kessler & McClellan (1996), *supra* note 51; Kessler and McClellan (2002) supra note 51; Kessler et al., *supra* note 52.

111 Most previous attempts to increase third-party coverage were designed to assist one of these three groups, *e.g.,* Medicare for seniors, Medicaid for low-income persons, and underwriting restrictions for high-risk persons.

112 Because persons with larger incomes have higher tax rates, both a standard deduction and less restrictive HSAs would allow persons with larger incomes to decrease their income tax bill by a larger amount than they would persons with less income.

113 *See* Blevins, *supra* note 79.

114 *See* Fairman, Rowe, Hassmiller, et al., *supra* note 100.

115 *See generally* King, *supra* note 108.

116 As noted earlier, many physicians do not accept Medicaid patients. *See* Cunningham & May, *supra* note 30.

117 However, for some recipients, it may be better to provide a comprehensive health plan or provide a subsidy at the point of care. *See* discussion and references cited, *supra* notes 92–94.

118 *See* discussion and references cited, *supra* note 31.

119 *See* discussion and references cited, *supra* note 85.

120 For example, Duke University's congestive heart failure program is a specialized program that produces excellent outcomes at low cost. *See* David J. Whellan et al., *The Benefit of Implementing a Heart Failure Disease Management Program*, 161 Archives Intern. Med. 2223, 2228 (2001).

121 *See, e.g.*, Madden, *supra* note 103.

122 It may not be necessary to subsidize all high-risk persons. Even in an unregulated market, most individuals are able to obtain guaranteed renewability as a feature of their insurance policy. Voluntary guaranteed renewability allows a person to renew his or her policy at a price similar to one's original rating class, even if one later becomes high-risk. *See e.g.*, Mark V. Pauly, *Regulation of Bad Things That Almost Never Happen, But Could: HIPAA and the Individual Insurance Market*, 22 Cato J. 59, 64 (2002). Similarly, health-status insurance would allow a low-risk person to purchase insurance to cover the cost of future premiums if one later becomes high risk. *See* John H. Cochrane, *Health-Status Insurance: How Markets Can Provide Health Security*, Pol'y Analysis No. 633 (Cato Institute, Washington, D.C.), (Feb. 2009). Finally, in an unregulated market, moderately high-risk patients are often able to obtain health insurance at a price only slightly higher than the price for average-risk persons. *See* Herring & Pauly, *supra* note 19, at 21.

123 For a discussion of high-risk pools, see Lori Achman & Deborah Chollet, The Commonwealth Fund, Insuring the Uninsurable: An Overview of State High-Risk Pools (2001).

124 For example, two reformers have proposed that the federal government provide a "payment," a form of subsidy, that a Medicare beneficiary could apply to the purchase of private health insurance. However, their proposal would limit the subsidy to the purchase of insurance from a regulated, Medicare exchange. *See* Alice Rivlin and Paul Ryan, A Long-Term Plan for Medicare and Medicaid 1 (Nov. 2010), *available at* http://paulryan.house.gov/UploadedFiles/rivlinryan.pdf.

125 A subsidy of a defined amount would provide an incentive for a beneficiary to choose the most cost-effective health insurance and medical care for his or her particular situation.

126 *See, e.g.*, Martin Feldstein, *Prefunding Medicare*, 89 Am. Econ. Rev. 222, 224 (1999).

127 Since 1984, Singapore has required individuals to save 6 to 8 percent of their wages to pay for health care, and most Singaporeans now pay directly for much of their care. *See* Taylor & Blair, *supra* note 67, at 3.

The Affordable Care Act: What's There to Like About It?

*Timothy S. Jost***

I. Not the "Best Health Care System in the World"

I find myself in the awkward and ironic position of being asked to defend an essentially Republican health reform statute to a readership that I imagine largely sees the legislation as a government takeover of our health care system. The Patient Protection and Affordable Care Act (ACA)[1] is not the legislation I would have drafted to reform our health care system. It is an unwieldy construct of conservative and mainstream health policy prescriptions, sprinkled with a few progressive ideas; much closer to historically market-based Republican health reform proposals than historically Democratic proposals based on social insurance models.

The ACA, however, addresses a number of very real problems. Every other developed nation has embraced as a fundamental public policy priority the task of making the wonders of modern medicine available to all, regardless of ability to pay. Access to health care, like access to education or the vote, is essential if people are to have the opportunity to participate as productive citizens in a free society. Most developed nations have, therefore, established national health services or social insurance systems to ensure access to health care for all, regardless of ability to pay. Of course, each of these systems has its own problems, but each makes basic health care available to all at a cost that is far less than what Americans pay for health care.

The United States has pursued a different path. Since the 1930s, we have relied on an employment-based health insurance system for financing health care.[2] This system has served us reasonably well. Insurance can be purchased by employment-based groups, particularly large groups, at much lower cost than individual insurance because administrative costs are lower and insurers face lower risks.[3] Employers also benefit because they have a healthier and more productive labor force. Pushed by unions and the threat of unionization and pulled by tax subsidies—which have become our third largest national health program and our largest tax expenditure—employment-based health insurance spread very rapidly in the 1950s and 1960s.[4] In the 1960s, Congress created two programs—Medicare for the elderly and disabled and Medicaid for the poor—that filled the most important gaps left by our employment-based system. By the 1980s, private health insurance covered four in five Americans.[5]

There were always gaps in coverage, however, and employment-based coverage has deteriorated dramatically in recent years. As of 2010, 49.9 million Americans, 16.3 percent of the population, lacked health insurance.[6] Over longer periods of time, the number of Americans uninsured at least temporarily is much higher, approaching 2 in 5 Americans.[7] Many are uninsured more or less permanently, although many also move in and out of the insurance market as their life circumstances change. Although Medicaid, supplemented by the State Children's Health Insurance Program, offers coverage to the elderly, disabled, and most poor children, Medicaid does not cover childless adults and in many states only covers very poor parents.

Of course, the uninsured are not necessarily denied access to health care. We retain a tattered safety net of federally-qualified health care centers, county hospitals, and free clinics that in some parts of the country offer some health care services to some people. Also, hospitals that participate in Medicare and have emergency rooms cannot refuse to stabilize the condition of persons whose emergent medical condition puts their health in immediate jeopardy,[8] although hospitals have no responsibility to offer continuing care once the emergency abates and do not have to offer even emergency care for free. No law guarantees access, however, to primary, preventive, or continuing chronic care, and we pay a high price in terms of morbidity and mortality for this lack.[9] 45,000 Americans die each year prematurely because of lack of health care coverage.[10] International statistics also demonstrate that financial barriers to care are a much greater problem in the United States than in other developed countries.[11]

The United States also measures poorly compared to other nations when we consider the cost of care. It is common knowledge that we spend far more on health care than any other nation, whether measured by percentage of gross domestic product or per capita expenditure.[12] To some extent this is to be expected. Health care is a luxury good and national expenditures per capita rise linearly with national wealth. But the United States is far above the curve—we spend much more than a country with our wealth would be expected to spend.[13] Other developed countries are much more effective than we are in controlling the cost of health care, and thus have more to spend, publicly or privately, on other desirable goods and services, including education and social services, which arguably make a greater contribution to a healthy population than does health care.

Finally, we do not get the quality of care that our expenditures would warrant. We have high infant mortality rates and low life expectancies, although that probably has more to do with other factors—like social inequality and poor public health infrastructure—than with lack of access to medical care. Although we do very well in some things, detection and treatment of cancer, for example, health care in the United States is on the whole not exceptional.[14] For example, the United States ranks last among 19 developed nations in mortality from preventable diseases, and we have lost ground relative to other nations over the past several years. [15]

II. The Affordable Care Act: A Conservative Response

This is the situation that we faced in 2008 when Barack Obama was elected president. Although many seem now to have forgotten it, America faced a terrifying economic crisis in 2008. Profligate spending and even more profligate tax cuts, coupled with reckless deregulation of the financial industry, had driven the country to the brink of financial collapse. The

***Timothy S. Jost is the Robert L. Willet Family Professor of Law at the Washington and Lee University School of Law.*

2008 election gave the Democratic party not only the White House, but also decisive control of the House and Senate. For the first time in decades, the Democrats faced the possibility of realizing their long-cherished dream of addressing the cost, quality, and, above all, access problems that plague our health care system.

But the balance of power in both the House and Senate were held by conservative rather than progressive Democrats, and the White House was held by a moderate Democrat committed to ending political divisiveness and conflict rather than to enacting a progressive agenda. Through the summer of 2009, moreover, there was a firm hope that moderate Republicans in the Senate would join with the Democrats in adopting truly bipartisan reform.

From the beginning, therefore, the ACA was built on mainstream or conservative, rather than progressive, principles. A single-payer system—Medicare for all—was never even considered. Congress even refused Americans the choice of a public insurance system as an alternative to private insurance coverage.

The resulting legislation was built on basic principles that have traditionally been associated with conservative advocacy organizations and scholars.[16] First, expansion of access for middle-income Americans is based on extending private insurance coverage rather than by building a new public system. Second, extension of coverage for this group is accomplished through the use of tax credits rather than direct payments. Third, health insurance exchanges will be used to encourage managed competition between insurers to bring down costs. Fourth, the problem of the cost of health care services is addressed through attempts to make markets function better rather than through price controls. Fifth, assistance for the truly needy is provided through the means-tested, federal-state Medicaid program. Sixth, there is no direct rationing of services. Seventh, the states will have the option of managing much of the program themselves to avoid the creation of a new federal bureaucracy. Many of these same principles are reflected in Paul Ryan's Roadmap for America, although he would, of course, disclaim any resemblance.[17]

In fact, many provisions of the ACA come from Republican Members of Congress. In its mark-up of reform legislation in June and July of 2009, the Senate Health Education and Labor Committee adopted 161 Republican amendments in whole or in revised form.[18] In the words of John McDonough, one of the key Senate staffers who worked on the bill:

> Republican ideas permeate the ACA. The individual mandate was advanced and broadly embraced by Republicans in the Clinton era, including Hatch and Grassley. Private-market subsidies to purchase private insurance was another cornerstone of the 1993 Republican alternative. No public-plan option was a persistent Republican demand. The Elder Justice Act was a priority for Hatch and Grassley. The Physician Payment Sunshine Act was another Grassley passion. Expanded fraud and abuse was a concern for Grassley and Tom Coburn (R-OK). Limiting the tax exclusion for everyone (through the "Cadillac" excise tax) and not just for the wealthy, was a cornerstone demand for Enzi. The young "invincible" catastrophic coverage option was a Snowe priority. Allowing consumers and businesses to buy health insurance across state lines was a priority for nearly every Republican member.[19]

Not surprisingly, public opinion surveys consistently show that many (about a quarter) of Americans who oppose the legislation believe that it did not go far enough—a fact concealed by polls that simply ask whether Americans support or oppose the legislation.[20] Undoubtedly, many supporters of the legislation, including myself, do so reluctantly, wishing it had gone further to cover more uninsured Americans and had relied more on public rather than private insurance to accomplish this end. Having said this, the benefits of the law cannot be gainsaid. The remainder of this essay will address those benefits.

III. Access to Health Care

First, the ACA will extend health insurance coverage to 30 to 33 million Americans.[21] About half of these will be covered through Medicaid expansions and half through private insurance purchased through premium tax credits. It is also quite possible that additional Americans will be covered through employer-sponsored insurance, as happened in Massachusetts after it adopted its health care reform law on which the ACA is modeled.[22] It is likely that some additional higher-income, self-employed Americans will purchase health insurance because of the minimum coverage requirement. Finally, an estimated 38 percent of those who remain uninsured will be potentially eligible for Medicaid but unenrolled.[23] Because the ACA allows hospitals to enroll presumptively eligible persons in Medicaid who require hospital care, this population will effectively have coverage if they have sufficiently serious problems to require hospital care.

As previously noted, this extension of insurance protection will improve health and save many American lives. It will also save many American households from financial ruin. Americans have a right to medical care in emergencies, but they do not have the right to free emergency care, and a day in a hospital can cost far more than the liquid assets of most American families.[24] Nothing presently guarantees Americans access to chronic, non-emergent care however, and the financial burden of such treatment can be devastating.

The Medicaid expansions will cover Americans under age 65 with incomes below 138 percent of the poverty level. The ACA required all states to cover this population as a condition of participating in Medicaid, but the Supreme Court ruling in June of 2012 made the Medicaid expansion optional with the states. If all states participate, the expansion will cover 17 million additional Americans.[25] Most of these will be adults who are presently not eligible for Medicaid, but many will be children, most of whom are currently eligible but many of whom are not enrolled. The CBO projects, however, that if states opt out of the Medicaid expansion, as many as 6 million fewer Americans will be covered, with 3 million of these covered additionally by the exchanges, resulting in 3 million fewer Americans having health insurance.[26]

Medicaid has its limitations. In particular, provider payments in many states are very low compared to commercial

insurance payments and many providers, especially physicians and dentists, choose to limit or refuse Medicaid patients. Nevertheless, evidence shows that Medicaid recipients have better access to care, report better health status, and have lower mortality rates than the uninsured.[27]

Approximately 20 million middle-income Americans will gain access to health care through advance premium tax credits, which will be available to households with incomes up to 400 percent of the poverty level.[28] These advance tax credits will supplement amounts paid by exchange enrollees to purchase insurance. The premium tax credits will be larger for lower-income households, smaller for households with higher incomes. Cost-sharing (deductibles, coinsurance, and copayments) will be relatively high under these policies compared to current employer-sponsored policies.[29] Indeed, the level of cost sharing will no doubt come as a shock to many of those insured. Particularly for households that choose the highest cost-sharing level bronze policy (with a 60 percent actuarial value), the coverage will essentially be for catastrophic expenses only. Households with incomes below 250 percent of poverty, however, will also receive cost-sharing reduction payments, which will reduce their expenditures when they actually receive care. Also, preventive services will be covered for all without cost sharing.

IV. Reforming Insurance Markets

The ACA also dramatically changes the way in which health insurance is sold in the individual and small group market. Traditionally, health insurers, like other insurers, have based their willingness to offer insurance and the premiums charged on the risk presented by the insurance applicant. This has meant that individuals who most need health care often cannot get insurance at all or find the cost of insurance unaffordable.[30] Insurers also often exclude from coverage pre-existing conditions, so that even when applicants with health problems can get insurance, they cannot get coverage for the problem for which they need help.

The ACA prohibits insurers from refusing to sell insurance to or to otherwise discriminate against an applicant because of health status. It only allows premiums for coverage in the individual and small group market to vary based on age (with a maximum ratio of 3 to 1), tobacco use (maximum variation 1.5:1), geography, and family size. Insurers cannot refuse to cover preexisting conditions. Gender underwriting is not permitted. The ACA also requires insurers to consider all of their individual enrollees in a single risk pool and all of their small group enrollees in another, with an option for states to combine the two pools. Further, it creates two short term and one permanent risk mitigation programs that will reward insurers that take on a sicker population and impose a cost on those that avoid risk.

Elimination of health status and gender underwriting and restricting age underwriting will likely make health insurance less expensive for women and for persons with health problems. In the non-group market it will make health insurance less expensive for older people and more for younger, although the opposite could happen for enrollees in small group coverage who purchase insurance through the exchange if they are underwritten as individuals rather than as a group.

This is in conflict with traditional Republican proposals for health insurance reform—association health plans and sale of health insurance across state lines—which would make health insurance more affordable for young healthy people, less affordable for older people and people with health issues.[31] Which is the better approach depends on what one considers fair.[32] If one believes that it is fair for individuals to each bear the full actuarial cost of their own situation, then the ACA is unfair. If one believes that all should have equal access to health care, regardless of current health status, then the ACA vision is fairer. Of course, over time virtually all of us encounter ill health, so the person who benefits from low rates at one point in an underwritten insurance scheme is likely to face higher rates, or to be unable to purchase insurance, at another. Also, the presence of tax subsidies shifts some of the cost from the insured to taxpayers generally. This is true of both the deductions and exclusions that currently apply to the employed and self-employed, which benefit mostly the wealthy and reasonably healthy, and of the new tax credits, which will benefit lower and middle-income Americans and many who are in poor health.

Because it is expected that insurers will cover a sicker population and that health insurance for the healthy will cost somewhat more under these rules, the ACA attempts to draw healthier individuals into the pool by imposing a penalty on individuals who can afford health insurance but choose not to purchase it. This mandate has been widely misunderstood ,and misrepresented. The mandate itself has several exceptions—it does not apply to undocumented aliens, the incarcerated, religious objectors, or members of health care sharing ministries. The penalty, however, has much broader exceptions. In particular, it does not apply to anyone who cannot find a basic health insurance policy for a price equal to or less than 8 percent of household income. Given the fact that family coverage is expected to cost $12,000 to $12,500 per year by 2016,[33] this means that a family that does not qualify for premium tax credits or for employer coverage, would have to earn $150,000 or more to be subject to a penalty.[34]

This "individual mandate" is one of the least popular provisions of the ACA and has been the focus of the federal litigation concerning the ACA. The Supreme Court in its June 2012 decision held that Congress lacked the power to adopt the mandate under the Commerce Clause.[35] The Court considered the mandate to be inseparable from the penalty that enforces it, however, and held that the penalty was properly adopted by Congress under its power to tax. The mandate was, therefore, upheld.

The ACA also reforms the way in which health insurance is sold in the individual and small group markets and bans certain common insurance practices. The law instantiates the concept of managed competition, another idea to come out of conservative economic thought.[36] The ACA invites the states to create state-based insurance markets called exchanges, and empowers the federal government to create exchanges in states that decline the invitation. In these markets, insurers will compete on price and quality, not, as they do now, on risk avoidance. All insurers will offer at least an essential health benefits package, based

initially, in all likelihood, on one of the largest small group plans in the state. All plans must be arrayed into one of four levels of cost sharing based on the actuarial value of the plan—the percentage of claim costs paid by the plan. A required Summary of Benefits and Coverage will, like the nutrition labels on foods or the energy efficiency labels on appliances, make it easy for insurance consumers to compare head-to-head the features of insurance plans and choose the plan that is best for them. The exchanges will also rate plans on price and quality and provide consumer satisfaction data.

The statute imposes a number of other insurance reforms, most of which are already in place. Plans must cover young adults up to age 26 on their parents' policies. This provision, which has extended coverage to over 3 million young adults, covers a population that costs little to insure but had one of the highest levels of uninsurance.[37] Another provision bans lifetime and annual limits on coverage. Lifetime limits are rarely exceeded, but where they apply, are often a matter of life and death. The annual limit requirement revealed an entire industry of "junk" insurance that offered almost useless coverage.[38] Insurers may not rescind policies through post-claims underwriting—accepting applications but canceling insurance retroactively once an enrollee files a claim. Insurers must offer both internal and external appeals from claims denials. Most insurers must spend at least 80 percent of their premium revenues on claims and quality improvement expenses (85 percent in the large group market) or rebate the difference to consumers. Insurers must also publicly justify unreasonable premium increases.

Most of these provisions have been quite popular.[39] Most were implemented in 2010 with little detrimental effect. In fact, the actuary of the Centers for Medicare & Medicaid Services (CMS) reports that in 2011 health care costs nationally decreased .1% because of the ACA.[40] Only two reforms provoked real (as opposed to manufactured) controversy. The annual limits requirement proved problematic for so-called "mini-med" coverage—insurance with very low annual limits. To avoid depriving people covered by these plans of health insurance, HHS, pursuant to statutory authority, provided temporary waivers to plans that failed to meet this requirement. The waivers will expire in 2014 when all plans must eliminate annual limits.[41] Several states asked for adjustments of the medical loss ratio requirement because of potential disruption to their states' insurance markets.[42] These were granted in some states, but in most states fears of disruption proved unfounded. Insurers recently returned $1.1 billion dollars to consumers in medical loss ratio rebates.[43] More importantly, the medical loss ratio requirement has incentivized insurers to become more efficient and to hold their premium increases in line with increases in medical costs.

V. Improving Medicare

The ACA makes important changes to expand benefits under the Medicare program. The Medicare "doughnut hole," which resulted from the attempt by Republicans in drafting the 2003 Medicare Modernization Act to keep prescription drug coverage both affordable and attractive to relatively healthy enrollees, is being closed through a combination of brand name drug discounts and coverage expansion for generics. Preventive services are covered without cost-sharing, including a free annual wellness visit.

The ACA also expands access to care by providing significant funding for community health centers, the National Health Services Corp, and school based health care programs, and reforms the Indian Health Service. It provides significant funding for community preventive care programs and for expanding the health care workforce.

VI. Controlling Health Care Costs

While the primary focus of the ACA is on expanding access to health care, it also contains a number of cost saving initiatives. Cutting health care costs is never easy. Shifting costs is easier. Costs can be shifted to patients by increasing cost-sharing or to enrollees in public programs by capping or reducing public support, for example, by providing vouchers rather than coverage. But cutting costs requires either reducing the volume of services received or the price paid for services. Attempts to limit the provision of services result in cries of rationing while efforts to reduce prices provoke intensive (and usually effective) special interest lobbying.

The Congressional Budget Office has most recently scored the repeal of the ACA as increasing the federal budget deficit by $109 billion over the 2013–2022 period.[44] While the net cost of the coverage increases will be $1171 billion over 10 years, it will be offset by $711 billion in savings and $569 billion in new revenues.[45] Most of the savings come from reducing the growth in expenditures for Medicare providers by demanding increased productivity, cutting expenditures to cover uncompensated care provided by hospitals (since fewer uninsured will be needing free care), and decreasing payments for Medicare Advantage managed care plans, which have long been paid dramatically more than the Medicare program pays for traditional Medicare.[46] The ACA also includes a "fail-safe" mechanism to cut costs, the Independent Payment Advisory Board, which has the task of making proposals to Congress to cut Medicare spending if it exceeds set targets.

The ACA opens the door to longer term cost controls as well. The Center for Medicare and Medicaid innovation is tasked with coming up with approaches that move away from inherently inefficient fee-for-service provider payment toward payment approaches that encourage better coordinated and more efficient care. The Medicare shared savings (accountable care organization) program and bundled-payment initiatives are examples of this. The Patient Centered Outcomes Research program holds the promise of identifying useless medical interventions, and concomitant savings that can result if we stop paying for such services. An entire chapter of the ACA is dedicated to fraud and abuse provisions, including provisions to prevent as well as punish fraud and abuse. The exchanges are, of course, based on the concept of managed competition, and on the hope that requiring insurers to compete based on price and quality rather than through risk selection will bring down the cost of insurance, and possibly with it the cost of care.

VII. Improving the Quality of Health Care

The ACA also attempts to improve the quality of health

care. It calls for a national quality strategy and for initiatives to implement it. Insurers are encouraged to create programs and incentives to improve outcomes of care, reduce rehospitalizations, improve patient safety and prevent medical errors, encourage prevention and wellness, and reduce racial disparities. The ACA contains new initiatives within Medicare to pay for performance and to increase information on quality to empower consumers. A number of provisions of the ACA encourage better coordination and integration of care, including increased use of electronic medical records. In sum, the ACA includes payment incentives, public disclosure, and regulatory responses intended to reward good quality care and improve care that is deficient.

VIII. Conclusion

Will all of this work? Can we increase access to care, constrain cost growth, and improve quality? Two and a half years have elapsed since the ACA was adopted and another year remains, as of this writing, before it is fully implemented. The ACA has faced determined and virulent opposition—lawsuits; an aggressive, unprincipled, and highly effective misinformation campaign; and vigorous attempts to block any cooperation by the states with implementation. It is hard to think of an example since desegregation in the 1950s and 1960s where the implementation of federal law has faced opposition of this magnitude.

Nevertheless, we are seeing progress—a dramatic reduction in the number of uninsured young adults, better access to preventive services, reduced drug costs for Medicare beneficiaries, expanded Medicaid in some states with further expansions to come—all with no increase to date in overall health care costs. Moreover, although opponents of the ACA have repeatedly voted to repeal it, they have offered no coherent strategy to replace it. For opponents, the uninsured are, apparently in the words of Senate Minority Leader Mitch McConnell, "not the issue."[47] Republican proposals may make bare-bones coverage less expensive for the young and healthy, but they do nothing to expand coverage to the uninsured or make health care affordable to those who need it most. The ACA is not a panacea, and it is definitely not the health reform legislation I would have enacted, but it is our best chance to make progress in dealing with the very serious problems that plague our health care system. Indeed, it may be the only chance we have for the next generation.

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