Health Care Reform Supplement

for

Health Care Law and Ethics, 7th edition

and

Health Care Finance and Regulation, 2nd edition

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Note: This Supplement may be integrated with the existing casebook editions in a variety of ways, including: covering it in its entirety; supplementing it with additional readings suggested in the notes; or covering each section of the Supplement alongside individual chapters in the casebook.

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I. REFORM OVERVIEW

The Struggle for Health Reform
Theda Skocpol and Vanessa Williamson

Before 2010, powerful entrenched interests had defeated health care reform in America for almost one hundred years. The first attempt at broad health insurance was in the 1910s, scotched by the insurance companies and the American Medical Association (AMA). The second opportunity came in the 1930s, when Roosevelt considered including health insurance in the Social Security legislation. It was left out because the AMA again mobilized against it. Harry Truman’s effort to pass “compulsory health insurance” – probably not the best label – was derided as socialism. The next effort was in the 1960s, when reformers decided to start on universal insurance by providing coverage for the elderly. This bill faced less opposition because the insurance companies didn’t really want to cover expensive, older, sick people – but Medicare did not lead to insurance for everyone. In fact, it pulled a major voting bloc, seniors, out of the fight for reform and gave conservatives a new scare tactic, convincing the elderly that Medicare might be cut back to pay for other people. In the 1970s, under Nixon and Carter, Democrats refused to accept a better deal than they would get now. And then there was the spectacular failure in 1993-94 under Hilary and Bill Clinton, which led to a Republican takeover of the Congress.

Thanks to this century of failed reform, the United States has been left with a system that is very unusual by international standards. Between the late 1800s and the end of World War II, most other advanced-industrial nations created systems of universal health insurance coverage. In America, a patchwork of policies leaves more than 46 million Americans uninsured. Most working-age people get their health insurance through their employers, while federal programs provide coverage for the elderly, the poor and near-poor, and for military veterans. And we pay an enormous premium for this inefficient, piecemeal system. The United States spends about twice as much per person as other industrial countries do on average, and more than fifty percent more than the next-biggest spender, Switzerland.

The complex system also disguises high risks. For doctors, getting paid requires filling out thousands of forms, without the certainty that an insurer will agree to pay. Hospitals have to cope with an unpredictable influx of uninsured people who appear in their emergency rooms. And many Americans, even those who are insured, face the risk that an illness can wipe out the family savings. In fact, catastrophic health care costs are the leading cause of bankruptcy in America.

Despite the complexities and costs of the existing private and public patchwork that makes up the nation’s health care system, Democrats were committed to modifying the system rather than replacing it root and branch. Many supporters of health reform would prefer a “single payer” system like Canada’s, where the government handles all payments for health services delivered by private doctors and hospitals. Democratic Presidents and elected officials may agree that such a system would be more efficient and less costly in principle, but in practice they

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are not prepared to disrupt existing arrangements between employers and private insurance
companies (which are major employers in their own right). So Democrats since the 1970s have
advocated reforms in existing arrangements. But preserving the employer core of the system
also means taking a very mature system and simultaneously trying to improve its efficiency
while expanding its reach. It means trying to squeeze out the resources to cover the uninsured,
while readjusting existing institutions to operate more effectively and at lower cost.

This is a heavy lift politically. Most Americans do not believe that you can pay for forty-
six million more people and save money at the same time. No health economists will convince
them otherwise. Even more telling, many powerful groups and economic interests have a stake in
the current broken system – where one person’s waste is another’s cherished benefit or corporate
profit. Insurance companies, pharmaceutical manufacturers, and hospital systems all find aspects
of the current health system very profitable, indeed. Unions, too, have a strong incentive to
protect the very expensive health plans that generations of workers had fought for. During the
health reform battles of 2009 and early 2010, each of these powerful lobbies could stand in the
way of critical legislative provisions. And each interest found it easy to run advertisements
preying on public skepticism and aiming to convince people that reform would negatively affect
their own health care.

The challenges of a health care fight were certainly clear in the minds of the Democrats
in Congress and in the White House, especially those who had lived through the failed reform of
the Clinton years. One could easily imagine, particularly given the deepening economic crisis,
that health care would get pushed from the top of the agenda. And yet Obama declared during
the campaign and early in his presidency that he would make health care reform a priority in his
first term. . . .

[T]he White House outlined only general, popular principles to define what health care
reform would look like, and left the details to Congress. . . . Featuring broad principles was an
attempt to avoid “fighting the last war.” When President Clinton had sought health care reform,
the Administration had assembled a 500-person presidential commission headed by Hilary
Rodham Clinton, and presented a 1,342-page document to the Congress in the fall of his first
year in the presidency. The plan was so complex that nobody could understand it – except the
people who were going lose out under the new system, and they mobilized very effectively
against it. Not only did the entire reform get nixed – legislation did not make it out of a single
committee – but the debacle helped sweep the Republicans into Congress in the fall of 1994.
Determined not to repeat that mistake this time, Obama decided instead to give speeches
outlining broad, popular principles—health care for more people, insurance that is more reliable,
cost containment for business and lower prices for families, and better benefits for the uninsured
and the elderly. When it came to specific provisions – such as an individual mandate requiring
everyone to purchase insurance . . . – the Administration left the fight to Congressional
Democrats. The aim was to let Congressional committees work out compromises that could
actually pass the House and the Senate.

The Obama Administration did intervene, however, to try to manage and defuse
longstanding interests opposed to health care reform. On March 5, 2009, the White House held a
forum on health care reform that included representatives from insurance companies, doctors and
hospital groups, and the pharmaceutical industry. . . . [T]he strategy worked to a considerable
degree. By May 2009, six major advocates in the health care industry signed onto a letter
nominally supporting reform of health care and offering some voluntary cost-cutting measures. .
The Obama Administration also had some success getting concessions from popularly based interest groups. The Obama Administration worked with AARP to ensure seniors saw benefits from health care reform, including the closure of the gap in Medicare prescription drug coverage known as the “donut hole.” After a great deal of effort, the Administration also convinced the unions to accept some very limited taxes on the most expensive health care plans. The White House insistence on including some kind of “Cadillac tax,” as this measure was called, was partly about raising revenue to finance reform, and even more about creating credible cost controls for the future.

How Scott Brown Threatened – and Then Strengthened – Health Reform

Yet even this close to success, reform very nearly did not happen. In mid-January 2010, a special election was held to fill the Senate seat held for decades by a liberal champion of comprehensive health reform, Ted Kennedy of Massachusetts, who died in the late summer of 2009. Facing an inept Democratic opponent, Scott Brown promised to oppose costly deals in Washington DC and offered to protect Massachusetts, which already has universal health insurance coverage, from having to pay for benefits for people in other states. Brown won amidst low Democratic turnout, and with considerable support from blue collar workers.

After the surprise election of Scott Brown in Massachusetts, it looked very possible that, once again, as repeatedly over the past century, health reform would fail. Because of the threat of the filibuster, an evolution of Senate procedure beyond the original Constitutional scheme, major legislation required a 60-vote supermajority to move forward. Brown’s election made him the 41st Republican, which all in his party pledged to vote against reform.

For a time, the Democrats seemed paralyzed, despite their still sizable majorities in the House and the Senate. In due course, however, the Brown victory in Massachusetts spurred Democrats to cooperate to finish a bolder and more comprehensive health reform. Provoked in part by the announcement of huge insurance rate hikes – which reminded the public of the need for some new legislation to rein in insurance companies -- the President took the lead at a public health care summit. In taking responsibility for finishing health care reform, Obama gave the Democrats in Congress the cover they needed to put together a negotiated agreement between the House and Senate Democrats.

After some intricate maneuvering by Senate Majority Leader Harry Reid and House Speaker Nancy Pelosi, the House and Senate Democrats finally had the votes to pass health care reform – without the support of a single Republican. On Tuesday, March 23, 2010, several hundred people crowded into the East Room of the White House to watch President Barack Obama sign into law the Patient Protection and Affordable Health Care Act [whose major provisions are summarized in Table 1].
Table 1: Health Care Reform: Major Benefits

<table>
<thead>
<tr>
<th>[GOAL]</th>
<th>FINAL LAW [eff. 2014]</th>
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<tbody>
<tr>
<td>Universal Coverage</td>
<td>95% covered [up from current rate of 83% of legal U.S. residents under age 65].</td>
</tr>
<tr>
<td>Competition to Make Care More Affordable</td>
<td>Sets up state-based insurance exchange marketplaces. . .</td>
</tr>
<tr>
<td>Support for Low-to-Middle Income Americans</td>
<td>Expand Medicaid to all under 65 with incomes up to 133% of the FPL.</td>
</tr>
<tr>
<td><em>The federal poverty line (FPL) was set in 2009 at $10,830 for a single person and $22,050 for a family of four.</em></td>
<td>To families between 133 and 400% of the FPL, provide tiered premium credits so families contribute between 2 and 9.5% of income to paying for insurance, and subsidies to cover up to 94% of medical costs.</td>
</tr>
<tr>
<td>Support for Young Adults and the Elderly</td>
<td>Closes the “donut hole” gap in Medicare prescription drug benefits by 2020. Children can stay on their parents’ plans until age 26. Insurance companies cannot charge more than three times as much for older people’s premiums compared to those they offer younger people.</td>
</tr>
<tr>
<td>Effective Regulation</td>
<td>Prevents insurance companies from charging women higher premiums than men, excluding customers because of a “pre-existing condition,” rescinding a policy when a person becomes sick. Effective in 2010 for children, 2014 for adults.</td>
</tr>
<tr>
<td>Free-rider Penalty: Penalties on individuals without qualifying coverage and large employers not providing coverage.</td>
<td>[Starting in 2014, individuals must obtain insurance unless decent coverage would cost more than 8% of their income. Those who don’t comply must] pay a tax equal to the greater of 2% of household adjusted income or $695 per person up to $2085. Employers with more than 50 employees not offering coverage . . . pay $2000 times the number of full time employees minus 30. If employer does offer coverage [but coverage is inadequate or costs employees more than 9.5% of income, employers must pay $3000 for each employee who declines coverage and uses a tax credit to purchase insurance through the new exchange.] . . .</td>
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The Next Fights Over Reform Implementation

In many ways, of course, the enactment of the new laws in March 2010 marked a beginning, not an end, a promise of accomplishment, not a fait accompli. Like Social Security and Medicare, Affordable Care is likely to face obstacles and redirections long after passage of the legislation itself. Looking at the response so far to the passage of health care reform, we can discern the likely outlines of the upcoming battles over implementation.

After a year of confusing and ugly legislative wrangling, the public’s support for the new legislation is lukewarm, while on the far right, there is significant motivation to repeal the legislation entirely. . . . Within hours of the passage of health care reform, more than a dozen conservative state officials, most of them candidates for office in fall 2010, rushed to court to argue that the new laws are unconstitutional. Republicans in Congress promised their supporters a complete repeal of the new legislation. . . .

By the summer of 2010, cautious majorities of the American public seem more amenable to “wait and see” than total repeal . . . . Presumably, Republicans can elect a President in 2012 and then try to repeal Affordable Care. But by then, many Americans will be used to new insurance regulations that protect patients; young Americans will enjoy staying on parental health plans until age 26; older Americans will enjoy enhanced prescription drug coverage under Medicare . . . .

Instead of repeal, gradual chipping away at tax and regulatory and benefit provisions is more likely. Many of the most redistributive policies in the health care reform package do not come into effect until 2014. It is not impossible that . . . Congresses dominated by Republicans, or by Republicans and conservative Democrats, [could] take a series of quiet actions to modify the reform framework enacted in 2010.

In the end, much of the fight over implementation is likely to happen in a less-visible arena: the states. Affordable Care, in its final version, called for state-level health insurance marketplaces, rather than creating a national exchange. . . . The effectiveness of the health insurance exchange provision, therefore, is likely to vary across state lines – and it may be many years before we know whether particular state solutions to widespread problems of access and cost can serve as a model for additional states or the nation as a whole.

How ever the future implementation struggles play out, the passage of Affordable Care in 2010 is a remarkable achievement – enough to make a least a partial case that Barack Obama and the Democrats in Congress during 2009 and 2010 have fashioned parts of another New Deal. In a highly partisan atmosphere, in the midst of a burgeoning economic crisis, and with comparatively small majority compared to other Democratic presidents who have pushed through major social reforms, Obama sailed through a sea of entrenched interests and secured a wide-ranging and remarkably progressive health care bill, a bill that draws resources from the privileged to spread access to affordable health insurance to most of the U.S. citizenry. But Affordable Care is a blueprint far from fully implemented, and the bitter politics of comprehensive health reform continues. In the coming months and years, we will see to what extent the promise of Affordable Care can be made a reality.
On March 21, 2010, in an extraordinary Sunday night session, the House of Representatives gave final approval to President Obama’s long-sought health insurance plan in a partisan 219–212 vote. The bill had earlier passed the Senate on Christmas Eve 2009. Not a single Republican in either chamber voted for the bill. . . . More than 2,500 pages and 500,000 words long, the Patient Protection and Affordable Care Act (PPACA) represents the most significant transformation of the American health care system since Medicare and Medicaid. It will fundamentally change nearly every aspect of health care from insurance to the final delivery of care.

The final legislation is, in some ways, an improvement over earlier versions. It is not the single-payer system sought by many liberals. Nor did it include the interim step of a so called “public option” that would likely have led to a single-payer system in the long run. The employer mandate is far less onerous than the 8 percent payroll tax once championed by the House. And the proposed income tax surtax on the wealthy has been dropped. But that does not mean that this is, as the president has claimed, a “moderate” bill.

It mandates that every American purchase a government-designed insurance package, while fundamentally reordering the insurance market and turning insurers into something resembling public utilities. . . . Insurance coverage will be extended to millions more Americans as government subsidies are expanded deep into the middle class. Costs will be shifted between groups, though ultimately not reduced. And a new entitlement will be created, with the threat of higher taxes and new debt for future generations. In many ways, it has rewritten the relationship between the government and the people, moving this country closer to European-style social democracy. . . . It seems almost certain, therefore, that the debate over health care reform will be with us for some time to come.

In the meantime, the legislation has spawned enormous confusion. Insurance companies report people calling and asking, “Where do we get the free Obamacare, and how do I sign up for that?” But for good or ill, those expecting immediate change are likely to be disappointed. Most of the major provisions of the legislation are phased in quite slowly. The most heavily debated aspects, mandates, subsidies, and even most of the insurance reforms don’t begin until 2014 or later. . . .

### Individual and Employer Mandates
Perhaps the single most important piece of this legislation is its individual mandate, a legal requirement that every American obtain health insurance coverage that meets the
government’s definition of “minimum essential coverage.” Those who don’t receive such coverage through government programs, their employer, or some other group would be required to purchase individual coverage on their own. This individual mandate is unprecedented in U.S. governance. . . . Moreover, the individual mandate raises serious constitutional questions.

Under the new law, beginning in 2014, those who fail to obtain insurance so would be subject to a tax penalty. That penalty would be quite mild at first, either $95 or one percent of annual income in 2014, whichever is greater. But it ramps up quickly after that, . . . [to] the greater of $695 or 2.5 percent of annual income . . . Individuals will be exempt from the penalties if they . . . are unable to obtain insurance that costs less than 8 percent of their gross incomes. . . . While the law imposes penalties for failure to comply, . . . it does not contain any criminal penalties for failing to comply, and it forbids the use of liens or levies to collect the penalties. However, the IRS . . . may withhold tax refunds to individuals who fail to comply with the mandate. . . .

Interestingly, the law may have created the worst of both worlds, a mandate that is costly and violates individual liberty, but one that is still weak enough that it may be cheaper for many individuals to pay the penalty than to purchase insurance. As a result it may fall far short of its proponents’ goal of bringing young and healthy individuals, who today frequently forego insurance, into the insurance pool . . .

Massachusetts’ experience with an individual mandate yielded just such a result. . . . [E]vidence suggests that Massachusetts residents are increasingly “gaming” the system: purchasing insurance when they know they are going to use health care services, then dropping it when they no longer need it. . . . Given that the penalties under the Massachusetts mandate are actually stronger than those under the Patient Protection and Affordable Care Act, this does not bode well for the national plan.

The new law also contains an employer mandate, although it is watered down from the proposal that passed the House last year. . . . [B]eginning in 2014, if a company with 50 or more full-time employees (or the equivalent) does not provide health insurance to its workers, and as a result even a single worker qualifies for a subsidy to help purchase insurance through the exchange (see below), the company must pay a tax penalty of $2,000 for every person they employ full time (minus 30 workers.) Thus a company employing 100 workers would be assessed a penalty of $2,000 x 70 workers . . . . [A]s with the individual mandate, the penalty may be low enough that many businesses may find it less costly to “pay” than to “play. . . ."

Insurance Regulations

. . . The Patient Protection and Affordable Care Act imposes a host of new federal insurance regulations that will significantly change the way the health insurance industry does business. Some of these regulatory changes are likely to be among the law’s most initially popular provisions. But many are likely to have unintended consequences. Perhaps the most frequently discussed regulatory measure is the ban on insurers denying coverage because of preexisting conditions. . . . Specifically, the law would require insurers to “accept every employer and individual . . . that applies for such coverage.”

. . . [I]nsurers would be prohibited from making any underwriting decisions based on health status, mental or physical medical conditions, claims experience, medical history, genetic information, disability, [or] other evidence of insurability . . . . Insurers are also forbidden to
cancel insurance if a policyholder becomes sick. Finally, there will be limits on the ability of insurers to vary premiums on the basis of an individual’s health. That is, insurers must charge the same premium for someone who is sick as for someone who is in perfect health. Insurers may consider age in setting premiums, but those premiums cannot be more than three times higher for their oldest than their youngest customers. Smokers may also be charged up to 50 percent more than nonsmokers. The only other factors that insurers may consider in setting premiums are geographic location and whether the policy is for an individual or a family.

While the ban on medical underwriting may make health insurance more available and affordable for those with preexisting conditions and reduce premiums for older and sicker individuals, it will also increase premiums for younger and healthier individuals. The RAND Corporation recently conducted a study for the Associated Press concluding that premiums for the young would rise about 17 percent.

The law also places limits on deductibles. Employer plans may not have an annual deductible higher than $2,000. Family policies are limited to deductibles of $4,000 or less. There is an exception, however, for individuals under the age of 30, who will be allowed to purchase a catastrophic policy with a deductible of $4,000 for an individual, $8,000 for a family plan.

In addition, the law requires insurers to maintain a medical loss-ratio (that is the ratio of benefits paid to premiums collected) of at least 85 percent for large groups and 80 percent for small groups and individuals. Insurance companies who pay out benefits less than the required proportion of premiums, must rebate the difference to policy holders on an annual basis beginning in 2011. This requirement is intended to force insurers to become more efficient by reducing the amount of premiums that can be used for administrative expenses (and insurer profits). However, insurance overhead includes many useful services and programs. These include efforts to monitor patient care to ensure those with chronic medical conditions are getting appropriate care, exactly the type of program that President Obama says he wants to encourage, and efforts to combat fraud and abuse. Those programs can actually reduce overall costs and result in lower insurance premiums. Forcing insurers to abandon those efforts could have the perverse effect of increasing costs to consumers.

**Subsidies**

The number one reason that people give for not purchasing insurance is that they cannot afford it. Therefore, the legislation’s principal mechanism for expanding coverage (aside from the individual and employer mandates) is to pay for it, either through government-run programs such as Medicaid or through subsidizing the purchase of private health insurance.

Starting in 2011, states are required to expand their Medicaid programs to cover all U.S. citizens with incomes below 133 percent of the poverty level (currently, $14,404 for an individual; $29,327 for a family of four; . . . . The primary result of the law’s Medicaid expansion would be to extend coverage to the parents in low-income families and to childless adults. In particular, single, childless men will now be eligible for Medicaid. . . . Initially, the federal government will pay 100 percent of the cost for new enrollees. However, beginning in 2017, states will be required to pick up a portion of the cost . . . The impact on state budgets would vary dramatically . . .
Individuals with incomes too high to qualify for Medicaid but below 400 percent of the poverty level ($88,000 per year [currently, for family of four]) will be eligible for subsidies . . . in the form of refundable tax credits. . . . There are actually two separate credits designed to work more or less in conjunction with one another. The first is a “premium tax credit.” The credit is calculated on a sliding scale according to income in such a way as to limit the total proportion of income that an individual would have to pay for insurance. Thus, individuals with incomes between 133 and 200 percent of the poverty level will receive a credit covering the cost of premiums up to four percent of their income, while those earning 300–400 percent of the poverty level will receive a credit for costs in excess of 9.5 percent of their income.

The second credit, a “cost-sharing credit” provides a subsidy for a proportion of out-of-pocket costs, such as deductibles and co-payments. Those subsidies are also provided on a sliding income-based scale, so that those with incomes below 150 percent of the poverty level receive a credit that effectively reduces their maximum out-of-pocket costs to 6 percent of a plan’s actuarial value, while those with incomes between 250 and 400 percent of the poverty level would, after receiving the credit, have maximum out-of-pocket costs of no more than 30 percent of a plan’s actuarial value.

The net result of this rather complex formula is that a family of four with an annual income of $30,000 per year, purchasing an insurance policy that cost $9,435, would receive a federal subsidy of $8,481, and have to pay $954 themselves. If the same family had an income of $65,000 per year, they would receive a subsidy of $3,358 and pay $6,077 themselves. As with many tax credits, the phase-out of these benefits creates a high marginal tax penalty as wages increase. In some cases, workers who increase their wages could actually see their after-tax income decline as the subsidies are reduced. . . .

All together, this law represents a massive increase in the welfare state, adding millions of Americans to the roll of those dependent, at least to some extent, on government largess. Yet for all the new spending, the Patient Protection and Affordable Care Act falls short of its goal of achieving universal coverage . . .

The Exchanges

Perhaps the most fundamental reordering of the current insurance market is the creation of “exchanges” in each state. . . . The exchanges would function as a clearinghouse, a sort of wholesaler or middleman, matching customers with providers and products. Exchanges would also allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, which are currently enjoyed by large employers. . . .

Beginning in 2014, one or more exchanges would be set up by each state and largely operated according to rules developed by that state. States would also have the option of joining with other states and creating regional exchanges. If a state refuses to create an exchange, the federal government is empowered to set one up within that state. States are given considerable discretion over how the exchanges would operate, but some of the federal requirements are significant . . .

Initially, only businesses with fewer than 50 employees, or uninsured individuals, or the self-employed may purchase insurance through the exchange. Members of Congress and senior
congressional staff are also required to purchase their insurance through the exchange. However, beginning in 2017, states have the option of opening the exchange to large employers.

Insurance plans offered for sale within the exchanges would be grouped into four categories based on actuarial value: bronze, the lowest cost plans, providing 60 percent of the actuarial value of a standard plan as defined by the secretary of HHS; silver, providing 70 percent of the actuarial value; gold, providing 80 percent of the actuarial value; and platinum, providing 90 percent of the actuarial value. In addition, exchanges may offer a special catastrophic plan to individuals who are under age 30 or who have incomes low enough to exempt them from the individual mandate. . . . CBO estimates that premiums for bronze plans would probably average between $4,500 and $5,000 for an individual and between $12,000 and $12,500 for family policies. The more inclusive policies would have correspondingly higher premiums. . . .

Exactly how significant the exchanges will prove to be remains to be seen. . . . However, one should be skeptical of claims that the exchange will reduce premiums. . . .

**Medicare Cuts**

Despite denials from the Obama administration and Democrats in Congress, the legislation does cut Medicare—and it should! Medicare is facing unfunded liabilities of $50 trillion to $100 trillion depending on the accounting measure used, making future benefit cuts both inevitable and desirable. Of course it would have been better, if the savings from any cuts had been used to reduce the program’s future obligations rather than to fund a brand new entitlement program. . . .

The bill would change the way payments are calculated for Medicare Advantage. Currently Medicare Advantage programs receive payments that average 14 percent more than traditional fee-for-service Medicare, something that Democrats have derided as wasteful. However, the program also offers benefits not included in traditional Medicare. . . . The law imposes a new competitive bidding model on the Medicare Advantage program that will effectively end the 14 percent overpayment. . . . In response, many insurers are expected to stop participating in the program, while others will increase the premiums they charge seniors. . . . Other Medicare cuts include freezing reimbursement rates for home health care and inpatient rehabilitative services and $1 billion in cuts to physician owned hospitals.

And, for the first time, the secretary of HHS would be permitted to use comparative effectiveness research in making reimbursement decisions. The use of comparative effectiveness research has been extremely controversial throughout this debate. On the one hand, . . . Medicare spending varies wildly from region to region, without any evidence that the variation is reflected in the health of patients or procedural outcomes. A case could certainly be made that taxpayers should not have to subsidize health care that has not proven effective, nor can Medicare and Medicaid pay for every possible treatment regardless of cost-effectiveness.

On the other hand, the use of such research in determining what procedures would be reimbursed could fundamentally alter the way medicine is practiced and could interpose government bureaucracies in determining how patients should be treated. . . . There is no doubt that national health care systems in other countries use comparative effectiveness research as the basis for rationing. . . . And the president has named as the new director of the Center for Medicare and Medicaid Services, Dr. Donald Berwick, who is an outspoken admirer of the
British National Health Service, and particularly its National Institute for Clinical Effectiveness [NICE], which makes such cost-effectiveness decisions.

Finally, the new law establishes a new Independent [Payment] Advisory [Board] (IPAB) which would have the power to recommend changes to the procedures that Medicare will cover, and the criteria to determine when those services would be covered, provided its recommendations “improve the quality of care” or “improve the efficiency of the Medicare program’s operation.” Starting in 2013, if Medicare spending is projected to grow faster than the combined average rate of general inflation and medical inflation (averaged over five years), [IPAB] must submit recommendations bringing spending back in line with that target. Beginning in 2018, the annual spending target becomes the rate of GDP growth plus 1 percent. Once [IPAB] makes its recommendations, Congress would have 30 days to vote to overrule them. If Congress does not act, the secretary of HHS would have the authority to implement those recommendations unilaterally.

Unfortunately, [IPAB] is prohibited from making any recommendation that would “ration care,” increase revenues, or change benefits, eligibility, or Medicare beneficiary cost-sharing (including Medicare premiums). That leaves [IPAB] with few options beyond reductions in provider payments. . . . With Medicare already under-reimbursing providers, further such cuts would have severe consequences, including driving physicians from the program and increased cost-shifting to private insurance. More likely, therefore, [IPAB] will end up as neutered as previous attempts to impose fiscal discipline on government health care programs.

On the other side of the ledger, the legislation increases subsidies under the Medicare Part D prescription drug program. . . . Starting in 2011, a slow reduction in the amount that seniors have to pay out-of-pocket within the “donut hole” begins, eventually reducing that amount from the current 100 percent to 25 percent by 2020. Part of the cost of filling the donut hole will be borne by pharmaceutical companies, who will be required to provide a 50 percent discount on the price of brand-name drugs. . . .

**Taxes**

The Patient Protection and Affordable Care Act imposes more than $669 billion in new or increased taxes over the first 10 years. These include

- Tax on “Cadillac” Insurance Plans.
- Payroll Tax Hike.
- Tax on Investment Income.
- Tax on Prescription Drugs.
- Tax on Medical Devices.
- Tax on Tanning Beds.
- .

The combination of taxes and subsidies in this law results in a substantial redistribution of income. The new law will cost families earning more than $348,000 per year (top 1 percent of incomes) an additional $52,000 per year on average in new taxes and reduced benefits. In contrast, those earning $18,000–55,000 per year will see a net income increase of roughly $2,000 per family.

**Other Provisions**

The legislation includes a number of pilot programs designed to increase quality of health care or control costs. Most are well intentioned but unlikely to have significant impact, especially in the short term. These would include programs such as bundled payments, global payments, accountable-care organizations and medical homes through multiple payers and settings. It
would also create a new Center for Innovation within the Centers for Medicare and Medicaid Services (CMS) to evaluate innovative models of care.

The law would also reward hospitals for providing value-based care, and penalize hospitals that perform poorly on quality measures such as preventable hospital readmissions. Of greater concern is a provision to establish a private, nonprofit institute to conduct comparative effectiveness research. Critics fear that comparative effectiveness research will not simply be used to provide information, but to impose a government-dictated method of practicing medicine. The legislation prohibits use of the research to create health care practice guidelines or for insurance coverage decisions. The research would initially be informative only. Still, there is no doubt that many reformers hope to ultimately use the information to restrict the provision of “unnecessary” care.

The law attempts to increase the supply of primary-care physicians by shifting reimbursement rates for government programs, such as Medicare and Medicaid, to reduce payments to specialists while increasing reimbursement for primary care. Yet, what possible reason is there to believe that the federal government can (a) know the proper mix of primary-care physicians and specialists, and (b) fine-tune reimbursements in a way that will produce those results? Nothing in the government’s previous activities suggests that such central planning would be effective.

**Expanded, Not Universal, Coverage**

Passage of health care reform was heralded by some in the media as providing “near universal coverage.” But by this standard, the Patient Protection and Affordable Care Act falls far short of its goals. According to the Congressional Budget Office, the legislation would reduce the number of uninsured Americans by about 32 million people by 2019. Most of those gains in the number of insured will not occur until after 2014 when the mandates and subsidies kick in. And even by 2019, CBO expects there to be more than 23 million uninsured. About one-third of the uninsured would be illegal immigrants. But that would still leave 15–16 million legal, nonelderly U.S. residents without health insurance.

Supporters of the legislation point out that that would decrease the number of uninsured Americans to roughly 6–8 percent of non-elderly Americans, a far cry from universal coverage, but undoubtedly better than today’s 15 percent. It is also important to realize that roughly 47 percent of the newly insured will be put into the Medicaid. Given that roughly a third of physicians no longer accept Medicaid patients, these individuals may still find significant barriers to access, despite their newly insured status.

**Increased Spending, Increased Debt**

Health-care costs are rising faster than GDP growth and now total more than $1.8 trillion—more than Americans spend on housing, food, national defense, or automobiles. However, the Patient Protection and Affordable Care Act fails to do anything to reduce or even restrain the growth in those costs. This should not come as a big surprise. The primary focus of the legislation was to expand insurance coverage. Giving more people access to more insurance, not to mention mandating that current insurance cover more services, will undoubtedly result in more spending.

It is also worth noting that cost estimates for government programs have been wildly optimistic over the years, especially for health care programs. There is certainly reason to
believe that the costs of this law will exceed projections. For example, as discussed above, increased insurance coverage could lead to increased utilization and higher subsidy costs. At the same time, if companies choose to drop their current insurance and dump employees into subsidized coverage or Medicaid, it could substantially increase the program’s costs.

This is all taking place at a time when the government is facing an unprecedented budgetary crisis. The U.S. budget deficit hit $1.4 trillion in 2009, and we are expected to add as much as $9 trillion to the national debt over the next 10 years, a debt that is already in excess of $12 trillion and rising at a rate of nearly $4 billion per day. Under current projections, government spending will rise from its traditional 20–21 percent of our gross domestic product to 40 percent by 2050. That would require a doubling of the tax burden just to keep up.

The millions of Americans who purchase insurance on their own through the nongroup market will actually be worse off as a result of this law. According to CBO, their premiums will increase 10–13 percent faster than if the bill had not passed. Of course, for low- and some middle-income Americans, any increase in premiums will be offset by government subsidies. But individuals whose income falls in the range where subsidies begin to phase out, and those not receiving subsidies will likely see significant increases in what they have to pay.

Conclusion

Health care reform was designed to accomplish three goals: (1) provide health insurance coverage for all Americans, (2) reduce insurance costs for individuals, businesses, and government, and (3) increase the quality of health care and the value received for each dollar of health care spending. Judged by these goals, the new law should be considered a colossal failure.

The legislation comes closest to success on the issue of expanding the number of Americans with insurance. The law also makes some modest insurance reforms that will prohibit some of the industry’s more unpopular practices. However, those changes will come at the price of increased insurance costs, especially for younger and healthier individuals, and reduced consumer choice.

At the same time, the legislation is a major failure when it comes to controlling costs. While we were once promised that health care reform would “bend the cost curve down,” this law will actually increase U.S. health care spending. Clearly the trajectory of U.S. health care spending under this law is unsustainable. Therefore, it raises the inevitable question of whether it will lead to rationing down the road.

We should be clear, however. With a few minor exceptions governing Medicare reimbursements, the law would not directly ration care or allow the government to dictate how doctors practice medicine. There is no “death board” as Sarah Palin once wrote about in her Facebook posting. Even so, this law represents a fundamental shift in the debate over how to reform health care. It rejects consumer-oriented reforms in favor of a top-down, “command and control,” government-imposed solution. As such, it sets the stage for potentially increased government involvement, and raises the specter, ultimately, of a government-run single-payer system down the road.

The debate over health care reform now moves to other forums. Elections this fall are likely to see candidates campaigning in favor of repealing all or parts of the legislation. And while institutional barriers such as the filibuster and presidential veto make an actual repeal
unlikely, there will almost certainly be efforts by future congresses to delay, de-fund, or alter many aspects of the law. One thing is certain—the debate over health care reform is far from over.

The Health Bill Explained At Last

Theodore R. Marmor and Jonathan Oberlander
New York Review of Books, August 2010

... Republicans have sought to make health care reform Barack Obama’s “Waterloo” by scaring the public. Ominous and utterly false warnings about “death panels,” a government “takeover” of American medicine, and “pulling the plug on grandma” followed. The irony is that for all the apocalyptic rhetoric, the new health reform law is anything but radical. In fact, it closely resembles the 2006 reform in Massachusetts supported by then-governor Republican Mitt Romney. And most strikingly, it does not replace the current mix of US health insurance schemes with a single public health insurance program like Medicare. Instead, the 2010 reform legislation introduces a complex system of subsidies, mandates, regulations, and programs that build on our present patchwork arrangements.

The bill, known as the Patient Protection and Affordable Care Act, begins to take effect [in 2010] but many of its provisions will be carried out during the coming decade. As of now, a majority of working-age adults and their children—some 157 million people—obtain private health insurance through their employers, while virtually all Americans over age sixty-five, as well as younger adults with permanent disabilities, are covered by Medicare. Low-income Americans who fit certain demographic categories, such as pregnant women and children, have access to Medicaid. Still others depend on a loose health care safety net, including community health centers that provide subsidized care, as well as on hospital emergency rooms that must by law see all patients, which of course doesn’t mean they will get timely or adequate care.

There are sizable gaps in US health insurance coverage. A high percentage of workers in small businesses are not covered by their employers and find purchasing their own insurance prohibitively expensive. Those with preexisting conditions like diabetes or asthma face particularly serious obstacles since insurers vary premium rates by health status and regularly deny coverage to those they regard as expensive risks. Low-income adults without dependent children are generally not eligible for Medicaid, leaving many of the nation’s poor uninsured.

Despite such deep flaws in the US health care system, the central assumption of both the Obama administration and the Democratic leadership in Congress was that only legislation that did not seek to radically change it had a chance of success. That political calculation, in turn, was based on the view that the Clinton administration’s health reform effort failed during 1993–1994 because it tried to change too much and provoked too much opposition from insurance companies and other powerful interests.

This time around, reformers hoped to reassure the large number of insured Americans who say they are satisfied with their current coverage that they had nothing to fear from change. Democrats also wanted to work with rather than fight against the health care industry. They hoped to gain support from the insurance, hospital, and pharmaceutical industries, which stood to

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3 The authors are political science professors in the public health departments of Yale University and University of North Carolina, respectively.
gain financially from expanded insurance coverage and had the financial resources and political influence to undercut reforms they opposed. As a consequence, the creation of a Canadian-style health program, in which universal insurance—Medicare for all—is provided by the government, was never seriously considered. Such a reform would have caused, in the administration’s view, too much disruption of prevailing arrangements and led to an inflammatory and unwinnable debate over “socialized medicine.”

In building on the existing system, the 2010 reform law largely emulates the 2006 Massachusetts health reform, which expanded coverage by broadening eligibility for Medicaid, grouping the uninsured into a newly created purchasing pool, and providing them, according to their incomes, with subsidies to purchase insurance. Massachusetts residents are required to obtain health insurance or pay a fine. The 2010 law also followed Massachusetts in mostly deferring the harder question of how to reduce the rate of inflation of medical costs in favor of expanding coverage.

... Democrats added an important proposal to the Massachusetts model. They suggested that uninsured Americans should have access to a newly created public insurance plan modeled on Medicare. It was designed to be a means to control health care spending by using the substantial purchasing power and lower administrative costs of the US government. This proposal was opposed by conservative Democrats, Republicans, and the insurance industry. Although a weakened public plan passed in the House, Democratic leaders could not get it included in the final bill.

3.

How will the new law work? First, all Americans who earn less than 133 percent of the federal poverty level [amounting to roughly $15,000 for an individual or $30,000 for a family of four] will become eligible for Medicaid. For the first time, Medicaid will offer coverage solely on the basis of income and regardless of family circumstance—including the single adults without children who are now excluded. The Congressional Budget Office (CBO) estimates that, as a result, about 16 million Americans will gain insurance coverage through Medicaid. ... .

Most Americans under age sixty-five will continue to receive employer-sponsored coverage. As a new feature, children can stay on their parents’ insurance plans until age twenty-six. New regulations banning insurers from imposing caps on both annual and lifetime payments will also benefit policyholders. Larger employers will have to offer health coverage to their workers or pay a penalty ($2,000 per worker) to the federal government. Smaller employers with fewer than fifty workers will be exempt from this requirement, and, depending on their average wage, businesses with twenty-five or fewer workers are eligible for tax credits to help them buy health insurance for their workers.

The law also expands coverage by offering subsidies to uninsured Americans to purchase insurance in newly formed health benefit exchanges. Each state is expected to set up and administer these exchanges as a regulated market for health insurance. If a state chooses not to do so, its residents can join a federally sponsored exchange. In either case, people will choose from a variety of private insurance plans within each exchange, with federal subsidies available on a sliding scale to help them pay their premiums. Those with incomes up to 400 percent of the federal poverty level (i.e., now up to about $43,000 [for singles] or $88,400 [for a family of four]) will be eligible for subsidies. In all, 29 million Americans are expected to obtain insurance through the exchanges by 2019. ...

The insurance exchanges will be regulated extensively. Starting in 2014, insurers will not be able to deny coverage to would-be policyholders or charge them higher premiums because of
their health status (though insurers can vary premiums by age). Insurers will also be prohibited from retroactively canceling coverage for sick policyholders. Most Americans will be required to obtain health insurance or pay a federal tax penalty—starting in 2014 at $95 per person or 1 percent of taxable income, whichever is greater, and then increasing to $695 or 2.5 percent of taxable income by 2016.

The CBO estimates that 32 million Americans will gain coverage through the expansion of Medicaid, subsidies, and insurance exchanges. This will make an enormous difference to the financial circumstances of many Americans with modest means and large medical expenses. Contrary to what conservative critics have claimed, the reform will undoubtedly mean less, not more, rationing of medical care as tens of millions of uninsured persons gain access to health insurance.

By broadening health insurance coverage, the law moves the United States closer to the principle that no one should go without access to medical care. In regulating the health insurance industry, with provisions to end discrimination on the basis of preexisting conditions, it brings about a long-overdue expansion of federal authority. In these ways and more, the Affordable Care Act is a substantial achievement.

At the same time, large gaps remain between the problems of American medicine and the remedies that Congress has adopted. Even if the Affordable Care Act were fully implemented, an estimated 23 million people would still lack insurance in 2019. We cannot know precisely who will be without coverage a decade from now. But analysts expect that the uninsured will be made up of three groups: undocumented immigrants who are ineligible for federal subsidies or Medicaid; Americans who still find coverage, even with subsidies, too expensive to purchase on their own but aren’t poor enough to qualify for Medicaid; and healthy people who can afford to buy coverage but will instead choose the cheaper option of paying the penalty for not having insurance. In any case, the United States, alone among industrialized democracies, will likely continue to have a large uninsured population for years to come.

Nor does the legislation provide Americans with adequate safeguards against rising medical costs. Many Americans with health insurance will still face substantial and growing medical bills. . . . In fact, the expansion of insurance coverage and regulation described in the law is hardly straightforward. New insurance plans will be regulated differently than existing policies. . . . [I]nsurers whose profits are at stake can be expected to seek loopholes to evade the new regulations. According to the law, the secretary of health and human services must write the thousands of pages of regulations necessary to implement it, and these will be subject to congressional scrutiny and intense lobbying by the health care industry. . . . One consequence, then, of building on the existing system is that the new law will require coordination of a great many disparate policies if coverage goals are to be met and if the health insurance marketplace is to be transformed.

Perhaps the largest shortcoming of the reform, though, is the absence of reliable, system-wide controls on medical costs. The law takes steps to slow down the rate of increase in Medicare spending, such as cutting projected payments to hospitals. . . . Outside of Medicare, the measures to slow health care spending are far less impressive. Many health policy analysts believe that the law contains a serious instrument to restrain spending, namely the so-called “Cadillac tax” on expensive insurance plans. By taxing high-cost private insurance plans, insurers and employers will trim overly “generous” benefits and Americans will—so it is hoped—use fewer medical services of low value. Yet this controversial policy is not slated to begin until 2018 and there is no guarantee that a future Congress and president will implement it
then.

Taxing health care benefits—even if restricted to the most generous plans—is hardly popular and is fiercely resisted by labor unions. Furthermore, even if the Cadillac tax does go into effect and saves significant money, it could end up reducing benefits and raising costs for people who do not have comprehensive coverage. . . .

The law’s strategy to contain costs additionally rests on a series of reforms aimed at improving medical care delivery and health outcomes: paying hospitals on the basis of quality; bundling payments together for inpatient and outpatient care; funding research that compares the clinical effectiveness of medical treatment options; and providing greater coverage of preventive services. It also encourages the formation of so-called accountable care organizations that create networks of primary care doctors, specialists, and hospitals to care (and receive payments) for a defined set of patients. Many of these reforms will be implemented initially in Medicare—a newly established Medicare innovations center is charged with testing payment reform—with the hope that successful policies will then spread through the private sector.

Health and Human Services Secretary Kathleen Sebelius says that “every cost-cutting idea that every health economist has brought to the table is in this bill.” That is probably true—but it also shows that American health policy researchers pay scant attention to international experience. . . . The new law seems based on the hope that if a large variety of reforms are tested, at least some will succeed; but nobody knows how many will work in practice or whether they will save money at all.

We do know that other rich democracies that spend much less than the US on medical care do so largely by adopting budgetary targets for health expenditures and by tightly regulating what the governments and insurers pay hospitals, doctors, and other medical care providers. Outside of Medicare, the current reform contains no such measures.

The Obama administration, confronting enormous opposition over proposals to expand coverage, chose mostly to defer addressing the political problems of cost control. But the . . . issue cannot be avoided for long. . . . The expansion of coverage and the requirement that individuals purchase insurance, alongside rising premium costs, . . . will increase [pressure] on the federal government to moderate the growth in health care costs—especially in view of sizable budget deficits. . . .

Republicans are mounting a campaign to “reform and repeal” the law. . . . The political challenge to health reform is [serious]. Not only does the law lack support from a majority of Americans. . . . [I]f a Republican wins the presidency in 2012 and takes office with Republican majorities in Congress, then reform could be in serious difficulty.

That is one reason why Democrats frontloaded the law with some popular, low-cost programs. In 2010 alone, provisions that will go into effect include a prescription drug rebate for Medicare beneficiaries; health insurance tax credits for small businesses; the prohibition on insurance companies denying coverage to children with preexisting conditions; and the requirement that insurers allow parents to keep children on their plans until age twenty-six. It will be very difficult for Republicans to overturn these and other policies regulating health insurers that are likely to attract public support.

But the major insurance provisions in the health reform law—including expanded Medicaid and federal subsidies to help the uninsured purchase insurance—are not set to begin until 2014. Democrats devised this delay in large part to fit the ten-year cost of the bill within a self-imposed $1 trillion dollar limit on new federal spending for health reform. . . . The delayed
implementation also produced a major risk. . . . Congress could overturn or replace the core policies designed to expand coverage; they might well target the less popular measures such as the individual and employer mandates or even the cuts in Medicare spending growth that are crucial to financing the expansion of insurance coverage.

In the short term, if the reformers are to win a defensive struggle against repeal, they will need to clarify the benefits of reform for the public, no easy task given the extraordinary amount of misinformation that has been spread over the past two years. . . . As a result, there is enormous uncertainty about how well and how long the patchwork of health reforms adopted in 2010 will hold together.

Notes: Health Care Reform 2012

1. *What's in a Name?* The legislation’s full name is too lengthy to catch on, and its full abbreviation (PPACA) is so unpleasant sounding that there isn’t even agreement on how to pronounce it. (Versions include “packa” or “pee-packa” or “puh-PACK-a.”) “Obamacare” is widely used, but more often than not with a negative, often derisive, tone or intent. Therefore, the “Affordable Care Act” is the preferred short form, but it remains to be seen whether that, or “ACA,” will stick.

On the politics and process of enactment, see Lawrence Jacobs & Theda Skocpol, Health Care Reform and American Politics (Oxford Univ. Press, forthcoming 2010).

2. *TMI (Too Much Information).* The copious sources of information about health care reform are far more than any normal person can keep up with. But, a good starting point is the government’s main portal:

   www.healthcare.gov, especially these two sub-pages: www.healthcare.gov/law/about/ and
   www.healthcare.gov/center/

Links to a series of reports from the Congressional Research Service explaining various provisions of the new law in detail can be found at:

   http://coburn.senate.gov/public/index.cfm/healthcare

Other more-or-less neutral sources of information include:


From thoughtful advocacy perspectives, see

   www.commonwealthfund.org/Health-Reform.aspx
   www.rwjf.org/healthreform/
   www.healthcare.cato.org/
   www.heritage.org/Issues/Health-Care

This is an entertaining video illustrating the view from small businesses:


On insurance regulation, see www.naic.org/index_health_reform_section.htm.

See generally Symposium, 29 Health Aff. 1087 (2010); Symposium 29 Health Aff. 1284 (2010).

3. *Can’t Please Anyone.* One reason that cost containment measures are so subdued in the Affordable Care Act was to avoid the fevered opposition from major industry and professional
groups that doomed the Clinton reform efforts 15 years early. This was largely successful. Muted support, or at least absence of overt opposition, came from the AMA, the hospital industry, and larger insurers. The Pharmaceutical industry went so far as to pay for adds extolling the need for health care reform, featuring none other than the exact same “Harry and Louise” actors whom the insurance industry famously used to raise widespread public anxiety about the Clinton reform proposal. [www.en.wikipedia.org/wiki/Harry_and_Louise](http://www.en.wikipedia.org/wiki/Harry_and_Louise)

Among the range of views, consider also those of liberal physicians who favor a “single-payer” national health insurance system:

As much as we would like to join the celebration . . . , in good conscience we cannot. We take no comfort in seeing aspirin dispensed for the treatment of cancer. Instead of eliminating the root of the problem - the profit-driven, private health insurance industry - this costly new legislation will enrich and further entrench these firms. . . .

Millions of middle-income people will be pressured to buy commercial health insurance policies costing up to 9.5 percent of their income but covering an average of only 70 percent of their medical expenses, potentially leaving them vulnerable to financial ruin if they become seriously ill. Many will find such policies too expensive to afford or, if they do buy them, too expensive to use because of the high co-pays and deductibles.

Insurance firms will be handed at least $447 billion in taxpayer money to subsidize the purchase of their shoddy products. This money will enhance their financial and political power, and with it their ability to block future reform. . . .

The much-vaunted insurance regulations - e.g. ending denials on the basis of pre-existing conditions - are riddled with loopholes, thanks to the central role that insurers played in crafting the legislation. Older people can be charged up to three times more than their younger counterparts . . . .

Congress and the Obama administration have saddled Americans with an expensive package of onerous individual mandates, new taxes on workers' health plans, countless sweetheart deals with the insurers and Big Pharma, and a perpetuation of the fragmented, dysfunctional, and unsustainable system that is taking such a heavy toll on our health and economy today. This bill's passage reflects political considerations, not sound health policy. . . .

We pledge to continue our work for the only equitable, financially responsible and humane remedy for our health care mess: single-payer national health insurance, an expanded and improved Medicare for All.

Physicians for a National Health Program, Health Bill Leaves 23 Million Uninsured: A False Promise of Reform (March 22, 2010).

4. The Public Option that Wasn’t. An intermediate approach to private insurance and “Medicare for All” would be a “public option” that allowed people to purchase coverage from a government-run insurance plan like Medicare. A public option or “Medicare buy-in” appeared likely at an earlier point in the Congressional deliberations, and was contained in the House bill that initially passed, but this was dropped as a political compromise. The primary controversy was whether it is fair for the government to impose the same types of price controls on providers as it does under Medicare when it is competing with private insurers, who lack the same market clout. Some feared, but others hoped, that if the public option succeeded, then private insurers would be driven out of business and the market would move us toward national health insurance. Short of that, advocates believed that a public plan would impose strong discipline on market forces, requiring private insurers and providers to reduce their costs substantially.

5. *Procedural and Remedial Provisions.* Missing from the reform law is any extensive new set of legal remedies. Despite a plethora of new substantive rights, entitlements, and responsibilities, people are left for the most part to pre-existing sources of legal protection, through normal administrative and judicial processes. Perhaps this was based on the view that existing avenues of recourse are sufficient, or out of concern that adding new explicit procedural protections would be too controversial.

One noticeably absent legal provision is any change in medical malpractice law. Instead, the reform law merely funds more demonstration projects for liability reform at the state level.
II. INSURANCE REGULATION

National Federation of Independent Business  v. Sebelius

576 U.S. ___  (2012)

CHIEF JUSTICE ROBERTS.

Today we resolve constitutional challenges to two provisions of the Patient Protection and Affordable Care Act of 2010: the individual mandate, which requires individuals to purchase a health insurance policy providing a minimum level of coverage; and the Medicaid expansion, which gives funds to the States on the condition that they provide specified health care to all citizens whose income falls below a certain threshold. We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation's elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions. ...

I

In 2010, Congress enacted the Patient Protection and Affordable Care Act. The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care. The Act's 10 titles stretch over 900 pages and contain hundreds of provisions. This case concerns constitutional challenges to two key provisions, commonly referred to as the individual mandate and the Medicaid expansion.

The individual mandate requires most Americans to maintain "minimum essential" health insurance coverage. 26 U. S. C. § 5000A. The mandate does not apply to some individuals, such as prisoners and undocumented aliens. Many individuals will receive the required coverage through their employer, or from a government program such as Medicaid or Medicare. But for individuals who are not exempt and do not receive health insurance through a third party, the means of satisfying the requirement is to purchase insurance from a private company.

Beginning in 2014, those who do not comply with the mandate must make a "[s]hared responsibility payment" to the Federal Government. That payment, which the Act describes as a "penalty," is calculated as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance. In 2016, for example, the penalty will be 2.5 percent of an individual's household income, but no less than $695 and no more than the average yearly premium for ["“bronze level”"] insurance. The Act provides that the penalty will be paid to the Internal Revenue Service with an individual's taxes, and "shall be assessed and collected in the same manner" as tax penalties, such as the penalty for claiming too large an income tax refund. The Act, however, bars the IRS from using several of its normal enforcement tools, such as criminal prosecutions and levies. And some individuals who are subject to the mandate are nonetheless exempt from the penalty—for example, those with income below a certain threshold and members of Indian tribes.
On the day the President signed the Act into law, Florida and 12 other States filed a complaint ... subsequently joined by 13 more States, several individuals, and the National Federation of Independent Business. The plaintiffs alleged, among other things, that the individual mandate provisions of the Act exceeded Congress's powers under Article I of the Constitution. The District Court agreed, holding that . . . the individual mandate could not be severed from the remainder of the Act, and therefore struck down the Act in its entirety. . . . The Court of Appeals for the Eleventh Circuit . . . struck down only the individual mandate, leaving the Act's other provisions intact . . .

III. A

The Government's first argument is that the individual mandate is a valid exercise of Congress's power under the Commerce Clause and the Necessary and Proper Clause. According to the Government, the health care market is characterized by a significant cost-shifting problem. Everyone will eventually need health care at a time and to an extent they cannot predict, but if they do not have insurance, they often will not be able to pay for it. Because state and federal laws nonetheless require hospitals to provide a certain degree of care to individuals without regard to their ability to pay, hospitals end up receiving compensation for only a portion of the services they provide. To recoup the losses, hospitals pass on the cost to insurers through higher rates, and insurers, in turn, pass on the cost to policy holders in the form of higher premiums. Congress estimated that the cost of uncompensated care raises family health insurance premiums, on average, by over $1,000 per year.

In the Affordable Care Act, Congress addressed the problem of those who cannot obtain insurance coverage because of preexisting conditions or other health issues. It did so through the Act's "guaranteed-issue" and "community-rating" provisions. These provisions together prohibit insurance companies from denying coverage to those with such conditions or charging unhealthy individuals higher premiums than healthy individuals.

The guaranteed-issue and community-rating reforms do not, however, address the issue of healthy individuals who choose not to purchase insurance to cover potential health care needs. In fact, the reforms sharply exacerbate that problem, by providing an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage. The reforms also threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage. This will lead insurers to significantly increase premiums on everyone.

The individual mandate was Congress's solution to these problems. By requiring that individuals purchase health insurance, the mandate prevents cost-shifting by those who would otherwise go without it. In addition, the mandate forces into the insurance risk pool more healthy individuals, whose premiums on average will be higher than their health care expenses. This allows insurers to subsidize the costs of covering the unhealthy individuals the reforms require them to accept. The Government claims that Congress has power under the Commerce and Necessary and Proper Clauses to enact this solution.
...Given its expansive scope, it is no surprise that Congress has employed the commerce power in a wide variety of ways to address the pressing needs of the time. But Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product. ... The power to regulate commerce presupposes the existence of commercial activity to be regulated. If the power to "regulate" something included the power to create it, many of the provisions in the Constitution would be superfluous. ... Our precedent also reflects this understanding. As expansive as our cases construing the scope of the commerce power have been, they all have one thing in common: They uniformly describe the power as reaching "activity." ...

The individual mandate, however, does not regulate existing commercial activity. It instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority. Every day individuals do not do an infinite number of things. In some cases they decide not to do something; in others they simply fail to do it. Allowing Congress to justify federal regulation by pointing to the effect of inaction on commerce would bring countless decisions an individual could potentially make within the scope of federal regulation, and—under the Government's theory—empower Congress to make those decisions for him. ...

To consider [an] example in the health care market, many Americans do not eat a balanced diet, ... [which] increases health care costs to a greater extent than the failure of the uninsured to purchase insurance. ... Under the Government's theory, Congress could address the diet problem by ordering everyone to buy vegetables. ... That is not the country the Framers of our Constitution envisioned. ... Congress already enjoys vast power to regulate much of what we do. Accepting the Government's theory would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal government. ...

The individual mandate's regulation of the uninsured as a class is, in fact, particularly divorced from any link to existing commercial activity. The mandate primarily affects healthy, often young adults who are less likely to need significant health care and have other priorities for spending their money. ... The Government, however, ... regards it as sufficient to trigger Congress's authority that almost all those who are uninsured will, at some unknown point in the future, engage in a health care transaction. ... The proposition that Congress may dictate the conduct of an individual today because of prophesied future activity finds no support in our precedent. ... The Commerce Clause is not a general license to regulate an individual from cradle to grave, simply because he will predictably engage in particular transactions. Any police power to regulate individuals as such, as opposed to their activities, remains vested in the States.

The Government argues that the individual mandate can be sustained as a sort of exception to this rule, because health insurance is a unique product. According to the Government, upholding the individual mandate would not justify mandatory purchases of items such as cars or broccoli
because, as the Government puts it, "[h]ealth insurance is not purchased for its own sake like a car or broccoli; it is a means of financing health-care consumption and covering universal risks." But cars and broccoli are no more purchased for their "own sake" than health insurance. They are purchased to cover the need for transportation and food. . . . And for most of those targeted by the mandate, significant health care needs will be years, or even decades, away. The proximity and degree of connection between the mandate and the subsequent commercial activity is too lacking to justify an exception of the sort urged by the Government. . . .

2

The Government next contends that Congress has the power under the Necessary and Proper Clause to enact the individual mandate because the mandate is an "integral part of a comprehensive scheme of economic regulation"—the guaranteed-issue and community-rating insurance reforms. . . . [Interpreting the] power to "make all Laws which shall be necessary and proper for carrying into Execution" the powers enumerated in the Constitution, Art. I, § 8, cl. 18, we have been very deferential to Congress's determination that a regulation is "necessary." We have thus upheld laws that are "'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" But we have also carried out our responsibility to declare unconstitutional those laws that undermine the structure of government established by the Constitution. . . .

Applying these principles, the individual mandate cannot be sustained under the Necessary and Proper Clause as an essential component of the insurance reforms. Each of our prior cases upholding laws under that Clause involved exercises of authority derivative of, and in service to, a granted power. For example, we have upheld provisions permitting continued confinement of those already in federal custody when they could not be safely released; criminalizing bribes involving organizations receiving federal funds; and tolling state statutes of limitations while cases are pending in federal court. The individual mandate, by contrast, vests Congress with the extraordinary ability to create the necessary predicate to the exercise of an enumerated power.

This is in no way an authority that is "narrow in scope," or "incidental" to the exercise of the commerce power [quoting earlier precedents]. Rather, such a conception of the Necessary and Proper Clause would work a substantial expansion of federal authority. . . . Congress could reach beyond the natural limit of its authority and draw within its regulatory scope those who otherwise would be outside of it. Even if the individual mandate is "necessary" to the Act's insurance reforms, such an expansion of federal power is not a "proper" means for making those reforms effective. . . . The commerce power thus does not authorize the mandate.

[Justices Scalia, Kennedy, Thomas and Alito concurred with, but did not join, the Commerce Clause portion (III.A.) of this opinion. The other four justices dissented from this portion.]

B

That is not the end of the matter. Because the Commerce Clause does not support the individual mandate, it is necessary to turn to the Government's second argument: . . . the Government asks us to read the mandate not as ordering individuals to buy insurance, but rather as imposing a tax on those who do not buy that product. . . .
The most straightforward reading of the mandate is that it commands individuals to purchase insurance. After all, it states that individuals "shall" maintain health insurance. . . . [But] if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes. . . . Under that theory, the mandate is not a legal command to buy insurance. Rather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income. . . . The question is not whether that is the most natural interpretation of the mandate, but only whether it is a "fairly possible" one. . . . Granting the Act the full measure of deference owed to federal statutes, it can be so read, for the reasons set forth below. . . .

First, for most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more.\[fn8\] It may often be a reasonable financial decision to make the payment rather than purchase insurance, unlike [a] "prohibitory" financial punishment . . . . While the individual mandate clearly aims to induce the purchase of health insurance, it need not be read to declare that failing to do so is unlawful. Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS. . . .

Indeed, it is estimated that four million people each year will choose to pay the IRS rather than buy insurance. We would expect Congress to be troubled by that prospect if such conduct were unlawful. . . . Congress did not think it was creating four million outlaws. . . . [Instead], the shared responsibility payment merely imposes a tax citizens may lawfully choose to pay in lieu of buying health insurance. . . . We do not make light of the severe burden that taxation—especially taxation motivated by a regulatory purpose—can impose. But imposition of a tax nonetheless leaves an individual with a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice. . . .

[Justices Ginsburg, Breyer, Sotomayor, and Kagan joined this tax power portion of the opinion (III.B.).]

IV. A.

The States also contend that the Medicaid expansion exceeds Congress's authority under the Spending Clause. They claim that Congress is coercing the States to adopt the changes it wants by threatening to withhold all of a State's Medicaid grants, unless the State accepts the new expanded funding and complies with the conditions that come with it. This, they argue, violates the basic principle that the Federal Government may not compel the States to enact or administer a federal regulatory program. . . .

\[fn8\] In 2016, for example, individuals making $35,000 a year are expected to owe the IRS about $60 for any month in which they do not have health insurance. Someone with an annual income of $100,000 a year would likely owe about $200. The price of a qualifying insurance policy is projected to be around $400 per month.
Enacted in 1965, Medicaid offers federal funding to States to assist [low-income] pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care. See 42 U. S. C. § 1396a(a)(10). In order to receive that funding, States must comply with federal criteria governing matters such as who receives care and what services are provided at what cost. By 1982 every State had chosen to participate in Medicaid.

There is no doubt that the Act dramatically increases state obligations under Medicaid. The current Medicaid program requires States to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled. There is no mandatory coverage for most childless adults, and the States typically do not offer any such coverage. The States also enjoy considerable flexibility with respect to the coverage levels for parents of needy families. On average States cover only those unemployed parents who make less than 37 percent of the federal poverty level, and only those employed parents who make less than 63 percent of the poverty line.

The Medicaid provisions of the Affordable Care Act, in contrast, require States to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line. The Affordable Care Act provides that the Federal Government will pay 100 percent of the costs of covering these newly eligible individuals through 2016. In the following years, the federal payment level gradually decreases, to a minimum of 90 percent. In light of the expansion in coverage mandated by the Act, the Federal Government estimates that its Medicaid spending will increase by approximately $100 billion per year, nearly 40 percent above current levels.

In this case, the financial "inducement" Congress has chosen is much more than "relatively mild encouragement"—it is a gun to the head. The Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that "further payments will not be made to the State." A State that opts out of the Affordable Care Act's expansion in health care coverage thus stands to lose not merely "a relatively small percentage" of its existing Medicaid funding, but all of it. Medicaid spending accounts for over 20 percent of the average State's total budget, with federal funds covering 50 to 83 percent of those costs. The threatened loss of over 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.

The Government claims that the Medicaid expansion is properly viewed merely as a modification of the existing program because the States agreed that Congress could change the terms of Medicaid when they signed on in the first place. Congress has in fact done so, sometimes conditioning only the new funding, other times both old and new. The Medicaid expansion, however, accomplishes a shift in kind, not merely degree.

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5 [Authors’ note: Actually, about half the states provide at least some coverage for low-income childless adults, but the coverage usually is more limited than Medicaid’s full benefits, and federal funding is provided only through special “waivers” of normal Medicaid funding rules. Kaiser Commission on Medicaid and the Uninsured, Expanding Medicaid to Low-Income Childless Adults under Health Reform (2010), http://www.kff.org/medicaid/upload/8087.pdf]
The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage. . . . A State could hardly anticipate that Congress's reservation of the right to "alter" or "amend" the Medicaid program included the power to transform it so dramatically. . . .

[Justices Breyer and Kagan joined this portion of the opinion (IV. A.). Justices Scalia, Kennedy, Thomas and Alito concurred with, but did not join, this portion.]

B

Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. . . . As a practical matter, that means States may now choose to reject the expansion; that is the whole point. But that does not mean all or even any will. Some States may indeed decline to participate, either because they are unsure they will be able to afford their share of the new funding obligations, or because they are unwilling to commit the administrative resources necessary to support the expansion. Other States, however, may voluntarily sign up, finding the idea of expanding Medicaid coverage attractive, particularly given the level of federal funding the Act offers at the outset. . . .

[Justices Ginsburg, Breyer, Sotomayor, and Kagan joined this subsection IV.B., regarding the consequence of finding the Medicaid expansion coercive. The other four justices dissented. Overall, then, there are three majority coalitions, with only Justice Roberts joining all three, as summarized below.]
JUSTICE GINSBURG, concurring in part and dissenting in part.

I

. . . In enacting the Patient Protection and Affordable Care Act (ACA), Congress comprehensively reformed the national market for health-care products and services. By any measure, that market is immense. Collectively, Americans spent $2.5 trillion on health care in 2009, accounting for 17.6% of our Nation's economy. Within the next decade, it is anticipated, spending on health care will nearly double. . . .

Although every [person] will incur significant medical expenses during his or her lifetime, the time when care will be needed is often unpredictable. An accident, a heart attack, or a cancer diagnosis commonly occurs without warning. Inescapably, we are all at peril of needing medical care without a moment's notice. To manage the risks associated with medical care — its high cost, its unpredictability, and its inevitability — most people in the United States obtain health insurance. Many (approximately 170 million in 2009) are insured by private insurance companies. Others, including those over 65 and certain poor and disabled persons, rely on government-funded insurance programs, notably Medicare and Medicaid. Combined, private health insurers and State and Federal Governments finance almost 85% of the medical care administered to U. S. residents.

Not all U. S. residents, however, have health insurance. In 2009, approximately 50 million people were uninsured, either by choice or, more likely, because they could not afford private insurance and did not qualify for government aid. . . . Unlike markets for most products, however, the inability to pay for care does not mean that an uninsured individual will receive no care. Federal and state law, as well as professional obligations and embedded social norms, require hospitals and physicians to provide care when it is most needed, regardless of the patient's ability to pay. As a consequence, medical-care providers deliver significant amounts of care to the uninsured for which the providers receive no payment. . . .

Health-care providers do not absorb these bad debts. Instead, they raise their prices, passing along the cost of uncompensated care to those who do pay reliably: the government and private insurance companies. In response, private insurers increase their premiums, shifting the cost of the elevated bills from providers onto those who carry insurance. . . . And it is hardly just the currently sick or injured among the uninsured who prompt elevation of the price of health care and health insurance. . . . [B]ecause any uninsured person may need medical care at any moment and because health-care companies must account for that risk, every uninsured person impacts the market price of medical care and medical insurance. . . .

Aware that a national solution was required, Congress could have taken over the health-insurance market by establishing a tax-and-spend federal program like Social Security. Such a program, commonly referred to as a single-payer system (where the sole payer is the Federal Government), would have left little, if any, room for private enterprise or the States. Instead of going this route, Congress enacted the ACA, a solution that retains a robust role for private insurers and state governments. To make its chosen approach work, however, Congress had to use some new tools, including a requirement that most individuals obtain private health
insurance coverage. As explained below, by employing these tools, Congress was able to achieve a practical, altogether reasonable, solution.

Congress knew that encouraging individuals to purchase insurance would not suffice to solve the problem, because most of the uninsured are not uninsured by choice. Of particular concern to Congress were people who, though desperately in need of insurance, often cannot acquire it: persons who suffer from preexisting medical conditions. Before the ACA’s enactment, private insurance companies took an applicant's medical history into account when setting insurance rates or deciding whether to insure an individual. Because individuals with preexisting medical conditions cost insurance companies significantly more than those without such conditions, insurers routinely refused to insure these individuals, charged them substantially higher premiums, or offered only limited coverage that did not include the preexisting illness.

To ensure that individuals with medical histories have access to affordable insurance, Congress devised a three-part solution. First, Congress imposed a "guaranteed issue" requirement, which bars insurers from denying coverage to any person on account of that person's medical condition or history. Second, Congress required insurers to use "community rating" to price their insurance policies. Community rating, in effect, bars insurance companies from charging higher premiums to those with preexisting conditions.

But these two provisions, Congress comprehended, could not work effectively unless individuals were given a powerful incentive to obtain insurance. In the 1990’s, several States — including New York, New Jersey, Washington, Kentucky, Maine, New Hampshire, and Vermont — enacted guaranteed-issue and community-rating laws without requiring universal acquisition of insurance coverage. The results were disastrous. All seven states suffered from skyrocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers.

Congress comprehended that guaranteed-issue and community-rating laws alone will not work. When insurance companies are required to insure the sick at affordable prices, individuals can wait until they become ill to buy insurance. Pretty soon, those in need of immediate medical care — i.e., those who cost insurers the most — become the insurance companies' main customers. This "adverse selection" problem leaves insurers with two choices: They can either raise premiums dramatically to cover their ever-increasing costs or they can exit the market. In the seven States that tried guaranteed-issue and community-rating requirements without a minimum coverage provision, that is precisely what insurance companies did. See, e.g., Hall, An Evaluation of New York's Reform Law, 25 J. Health Pol'y, Pol'y & L. 71, 91-92 (2000).

Massachusetts, Congress was told, cracked the adverse selection problem. By requiring most residents to obtain insurance, the Commonwealth ensured that insurers would not be left with only the sick as customers. As a result, federal lawmakers observed, Massachusetts succeeded where other States had failed. In coupling the minimum coverage provision with guaranteed-issue and community-rating prescriptions, Congress followed Massachusetts' lead.

In sum, Congress passed the minimum coverage provision as a key component of the ACA to address an economic and social problem that has plagued the Nation for decades: the large
number of U. S. residents who are unable or unwilling to obtain health insurance. Whatever one thinks of the policy decision Congress made, it was Congress' prerogative to make it. Reviewed with appropriate deference, the minimum coverage provision, allied to the guaranteed-issue and community-rating prescriptions, should survive measurement under the Commerce and Necessary and Proper Clauses. . . .

II

. . . THE CHIEF JUSTICE insists, the uninsured cannot be considered active in the market for health care, because "[t]he proximity and degree of connection between the [uninsured today] and [their] subsequent commercial activity is too lacking." This argument has multiple flaws. First, more than 60% of those without insurance visit a hospital or doctor's office each year. Nearly 90% will within five years. An uninsured's consumption of health care is thus quite proximate . . . . Equally evident, . . . [n]o one knows when an emergency will occur, yet emergencies involving the uninsured arise daily. To capture individuals who unexpectedly will obtain medical care in the very near future, then, Congress needed to include individuals who will not go to a doctor anytime soon. . . .

The inevitable yet unpredictable need for medical care and the guarantee that emergency care will be provided when required are conditions nonexistent in other markets. That is so of the market for cars, and of the market for broccoli as well. Although an individual might buy a car or a crown of broccoli one day, there is no certainty she will ever do so. And if she eventually wants a car or has a craving for broccoli, she will be obliged to pay at the counter before receiving the vehicle or nourishment. She will get no free ride or food, at the expense of another consumer forced to pay an inflated price. Upholding the minimum coverage provision on the ground that all are participants or will be participants in the health-care market would therefore carry no implication that Congress may justify under the Commerce Clause a mandate to buy other products and services.

. . . THE CHIEF JUSTICE also calls the minimum coverage provision an illegitimate effort to make young, healthy individuals subsidize insurance premiums paid by the less hale and hardy. This complaint, too, is spurious. Under the current health-care system, healthy persons who lack insurance receive a benefit for which they do not pay: They are assured that, if they need it, emergency medical care will be available, although they cannot afford it . . . . In the fullness of time, moreover, today's young and healthy will become society's old and infirm. Viewed over a lifespan, the costs and benefits even out: The young who pay more than their fair share currently will pay less than their fair share when they become senior citizens. And even if, as undoubtedly will be the case, some individuals, over their lifespans, will pay more for health insurance than they receive in health services, they have little to complain about, for that is how insurance works. Every insured person receives protection against a catastrophic loss, even though only a subset of the covered class will ultimately need that protection. . . .

Recall that one of Congress' goals in enacting the Affordable Care Act was to eliminate the insurance industry's practice of charging higher prices or denying coverage to individuals with preexisting medical conditions. The commerce power allows Congress to ban this practice, a point no one disputes. Congress knew, however, that simply barring insurance companies from
relying on an applicant's medical history would not work in practice. Without the individual mandate, Congress learned, guaranteed-issue and community-rating requirements would trigger an adverse-selection death-spiral in the health-insurance market: Insurance premiums would skyrocket, the number of uninsured would increase, and insurance companies would exit the market. When complemented by an insurance mandate, on the other hand, guaranteed issue and community rating would work as intended, increasing access to insurance and reducing uncompensated care.

Asserting that the Necessary and Proper Clause does not authorize the minimum coverage provision, THE CHIEF JUSTICE focuses on the word "proper." A mandate to purchase health insurance is not "proper" legislation, THE CHIEF JUSTICE urges, because the command "under-mine[s] the structure of government established by the Constitution." . . . Lacking case law support for his holding, THE CHIEF JUSTICE nevertheless declares the minimum coverage provision not "proper" because it is less "narrow in scope" than other laws this Court has upheld under the Necessary and Proper Clause. . . .

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V

. . . Medicaid is a prototypical example of federal-state cooperation in serving the Nation's general welfare. Rather than authorizing a federal agency to administer a uniform national health-care system for the poor, Congress offered States the opportunity to tailor Medicaid grants to their particular needs, so long as they remain within bounds set by federal law. In shaping Medicaid, Congress did not endeavor to fix permanently the terms participating states must meet; instead, Congress reserved the "right to alter, amend, or repeal" any provision of the Medicaid Act. . . . And from 1965 to the present, States have regularly conformed to Congress' alterations of the Medicaid Act.

THE CHIEF JUSTICE acknowledges that Congress may "condition the receipt of [federal] funds on the States' complying with restrictions on the use of those funds," but nevertheless concludes that the 2010 expansion is unduly coercive. His conclusion rests on [the premise that] . . . the Medicaid expansion is, in THE CHIEF JUSTICE's view, a new grant program, not an addition to the Medicaid program existing before the ACA's enactment. Congress, THE CHIEF JUSTICE maintains, has threatened States with the loss of funds from an old program in an effort to get them to adopt a new one. . . . THE CHIEF JUSTICE therefore — for the first time ever — finds an exercise of Congress' spending power unconstitutionally coercive.

Medicaid, as amended by the ACA, however, is not two spending programs; it is a single program with a constant aim — to enable poor persons to receive basic health care when they need it. . . . States have no entitlement to receive any Medicaid funds; they enjoy only the opportunity to accept funds on Congress' terms. . . . The Federal Government, therefore, is not, as THE CHIEF JUSTICE charges, threatening States with the loss of "existing" funds from one spending program in order to induce them to opt into another program. Congress is simply requiring States to do what States have long been required to do to receive Medicaid funding: comply with the conditions Congress prescribes for participation. . . .

Expansion has been characteristic of the Medicaid program. Akin to the ACA in 2010, the Medicaid Act as passed in 1965 augmented existing federal grant programs jointly administered with the States. Huberfeld, Federalizing Medicaid, 14 U. Pa. J. Const. L. 431, 444-445 (2011). States were not required to participate in Medicaid. But if they did, the Federal Government paid at least half the costs. To qualify for these grants, States had to offer a minimum level of health coverage to beneficiaries of four federally funded, state-administered welfare programs: Aid to Families with Dependent Children; Old Age Assistance; Aid to the Blind; and Aid to the Permanently and Totally Disabled. At their option, States could enroll additional "medically needy" individuals; these costs, too, were partially borne by the Federal Government at the same, at least 50%, rate.
Since 1965, Congress has amended the Medicaid program on more than 50 occasions, sometimes quite sizably. Most relevant here, between 1988 and 1990, Congress required participating States to include among their beneficiaries pregnant women with family incomes up to 133% of the federal poverty level, children up to age 6 at the same income levels, and children ages 6 to 18 with family incomes up to 100% of the poverty level. These amendments added millions to the Medicaid-eligible population.

Compared to past alterations, the ACA is notable for the extent to which the Federal Government will pick up the tab. Medicaid's 2010 expansion is financed largely by federal outlays. In 2014, federal funds will cover 100% of the costs for newly eligible beneficiaries; that rate will gradually decrease before settling at 90% in 2020. By comparison, federal contributions toward the care of beneficiaries eligible pre-ACA range from 50% to 83%, and averaged 57% between 2005 and 2008. Nor will the expansion exorbitantly increase state Medicaid spending. The Congressional Budget Office (CBO) projects that States will spend 0.8% more than they would have, absent the ACA. Whatever the increase in state obligations after the ACA, it will pale in comparison to the increase in federal funding.

Finally, any fair appraisal of Medicaid would require acknowledgment of the considerable autonomy States enjoy under the Act. Subject to its basic requirements, the Medicaid Act empowers States to "select dramatically different levels of funding and coverage, alter and experiment with different financing and delivery modes, and opt to cover (or not to cover) a range of particular procedures and therapies. States have leveraged this policy discretion to generate a myriad of dramatically different Medicaid programs over the past several decades." Ruger, Of Icebergs and Glaciers, 75 Law & Con-temp. Probs. 215, 233 (2012).

The alternative to conditional federal spending, it bears emphasis, is not state autonomy but state marginalization. In 1965, Congress elected to nationalize health coverage for seniors through Medicare. It could similarly have established Medicaid as an exclusively federal program. Instead, Congress gave the States the opportunity to partner in the program's administration and development.

To ensure that federal funds granted to the States are spent to "provide for the . . . general Welfare" in the manner Congress intended, Congress must of course have authority to impose limitations on the States' use of the federal dollars. This Court, time and again, has respected Congress' prescription of spending conditions, and has required States to abide by them. That is what makes this such a simple case, and the Court's decision so unsettling. Congress, aiming to assist the needy, has appropriated federal money to subsidize state health-insurance programs that meet federal standards. The principal standard the ACA sets is that the state program cover adults earning no more than 133% of the federal poverty line. Enforcing that prescription ensures that federal funds will be spent on health care for the poor in furtherance of Congress' present perception of the general welfare.

THE CHIEF JUSTICE asserts that the Medicaid expansion creates a "new health care program." Ante, at 54. Moreover, States could "hardly anticipate" that Congress would "transform [the program] so dramatically." Therefore, THE CHIEF JUSTICE maintains, Congress' threat to withhold "old" Medicaid funds based on a State's refusal to participate in the "new" program is a
"threat to terminate [an]other . . . independent gran[t]." And because the threat to withhold a large amount of funds from one program "leaves the States with no real option but to acquiesce [in a newly created program]," THE CHIEF JUSTICE concludes, the Medicaid expansion is unconstitutionally coercive. . . .

Congress styled and clearly viewed the Medicaid expansion as an amendment to the Medicaid Act, not as a "new" health-care program. To the four categories of beneficiaries for whom coverage became mandatory in 1965, and the three mandatory classes added in the late 1980's, see supra, at 41-42, the ACA adds an eighth: individuals under 65 with incomes not exceeding 133% of the federal poverty level. . . . Even if courts were inclined to second-guess Congress' conception of the character of its legislation, how would reviewing judges divine whether an Act of Congress, purporting to amend a law, is in reality not an amendment, but a new creation? At what point does an extension become so large that it "transforms" the basic law?

Justice SCALIA, Justice KENNEDY, Justice THOMAS, and Justice ALITO, dissenting.

. . . The Affordable Care Act seeks to achieve "near-universal" health insurance coverage. The two pillars of the Act are the Individual Mandate and the expansion of coverage under Medicaid. In our view, both these central provisions of the Act — the Individual Mandate and Medicaid Expansion — are invalid. It follows, as some of the parties urge, that all other provisions of the Act must fall as well. The following section explains the severability principles that require this conclusion. This analysis also shows how closely interrelated the Act is ....

The whole design of the Act is to balance the costs and benefits affecting each set of regulated parties. Thus, individuals are required to obtain health insurance. Insurance companies are required to sell them insurance regardless of patients' pre-existing conditions and to comply with a host of other regulations. And the companies must pay new taxes. States are expected to expand Medicaid eligibility and to create regulated marketplaces called exchanges where individuals can purchase insurance. Some persons who cannot afford insurance are provided it through the Medicaid Expansion, and others are aided in their purchase of insurance through federal subsidies available on health-insurance exchanges. The Federal Government's increased spending is offset by new taxes and cuts in other federal expenditures, including reductions in Medicare and in federal payments to hospitals. Employers with at least 50 employees must either provide employees with adequate health benefits or pay a financial exaction if an employee who qualifies for federal subsidies purchases insurance through an exchange. In short, the Act attempts to achieve near-universal health insurance coverage by spreading its costs to individuals, insurers, governments, hospitals, and employers — while, at the same time, offsetting significant portions of those costs with new benefits to each group. . . . [The dissenters therefore conclude that a defect in any major provision should bring down the entire Act.]
At the heart of the newly enacted federal health insurance reform legislation ("Health Reform Law") is an "individual mandate." . . . [This] has been held up as the "American" way to achieve universal coverage, where every citizen can choose her own insurance, and commercial insurers can compete for profit. By laying claims to coverage, choice, and competition, the mandate has garnered a strong and diverse set of supporters. Hillary Clinton and John Edwards championed the individual mandate during the 2008 Democratic primary race. Former Governor of Massachusetts Mitt Romney, a Republican, proposed it as a key element of the Commonwealth’s health reform, which was enacted into law by an overwhelmingly Democratic legislature in 2006. The health insurance industry, historically resistant to national reform, has supported an individual mandate and has even offered concessions in return for inclusion of the mandate in legislation. . . .

Yet, there is no clear expression of, or consensus as to, why we would want to increase coverage through an individual mandate. . . . I suggest in this article that there are three primary reasons that drive support for the individual mandate . . . which I characterize as paternalism, efficiency, and health redistribution . . . . First, some people are worried about the wellbeing of the uninsured themselves, motivated by the uninsured individual whose cancer or heart disease will go undiagnosed and lead to premature death or, if diagnosed, will cause him to choose between his financial and physical wellbeing because of the high costs of his medical care. . . . Alternatively, some are interested in their own bottom line, angry that the uninsured don’t “pay their share,” making insurance more expensive for everyone else. Their support for the mandate is animated by the stories of the 28 year-old who decided he was healthy enough to “go bare” without insurance coverage and then has a mountain biking accident that results in tens of thousands of dollars of emergency room care he can’t afford.

Others struggle morally with the fact that nearly 1/5 of all Americans lack insurance, particularly if they are poor or sick, and what such a reality says about us as a nation of people. They want to ensure that we create a system that enables all members of their community – locally and nationally – to have equitable access to good medical care when in need. . . . [T]he primary focus of this paper . . . [is] support[ing] the mandate for redistributive reasons so that the risk of poor health is shouldered more equally by all Americans. The mandate promotes such redistribution by requiring the uninsured who have arguably rationally opted out of the insurance market (because they are healthy and unlikely to need medical care) to buy health insurance nonetheless to finance care for those sicker or less lucky than themselves. When the healthy and the sick pool risk, it creates a redistribution of wealth from the healthy to the sick, which I call "health redistribution" in contrast to "income redistribution," whereby wealthy are taxed to provide health care for the poor (e.g., in Medicaid).

Advocates . . . argue, for example, that health redistribution enhances the political feasibility of funding subsidies for insurance coverage for the poor and sick, by facilitating

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subsidies within the bounds of a defined program and among a broader base, thus avoiding the sharp division between haves and have-nots created by income tax-based subsidies. . . . Effective health redistribution might also unlock greater insurance market efficiency by reducing practices of medical underwriting and risk selection.

Finally, I show that some scholars see health redistribution as a means to institutionalize a more solidaristic regime of health insurance in the U.S., where access to health care can be divorced from market forces or individual wealth. In other words, for some, implementing an individual mandate would be tantamount to asking Americans to act collectively so that everyone – rich, poor, sick, or healthy – can access medical care when in need, regardless of income or health status. This notion of health solidarity has deep roots in health care provision historically in the U.S., through mutual aid societies and religious organizations, and is a central attribute of health care in all other advanced nations. . . .

Yet, . . . the individual mandate will not be able to realize such benefits that rely upon its ability to promote health redistribution if it is implemented in a fragmented health insurance market. Fragmentation is an atomization of the health insurance market into numerous risk pools – a complex process that has been fueled by private market competition and exacerbated by regulation in both intentional and unintentional ways. Commercial insurers’ profit relies upon their ability to segment people into groups of predictable or similar risk and price according to risk or to select out good risks (i.e., cherry picking). To better manage risk and profit, insurers have carved up the insurance market into submarkets – large group, small group, and individual. Risk is not pooled among these three markets. This means that if healthy individuals are disproportionately insured in one market and sick in another, they don’t share in risk and medical costs. Furthermore, . . . risk pooling may be limited among individual insureds to the extent insurers are permitted under state law to design premiums and coverage based on projections of individual risk. . . . By creating such crevasses that limit the scope of risk pooling, fragmentation makes it impossible to distribute costs of poor health broadly among both healthy and sick . . . . Fragmentation is not an easy problem to fix. The most elegant solution may be a single payer system designed to completely eliminate fragmentation, [but this is not politically feasible]. . . .

By compelling everyone to be a consumer of insurance, the individual health insurance mandate might . . . eliminate adverse selection into health insurance markets. This is the primary motivation economists cite for the individual mandate. Adverse selection is a problem of information asymmetry in insurance markets. Insurers are concerned that those who seek insurance are more likely than average to consume medical care because of something the buyers know about their own health, family history, or behavior that insurers don’t know and can’t easily discover[,] . . . which creates inefficiency. Insurers have little concern of adverse selection with respect to large, employer-sponsored group insurance. Because these groups are formed for non-health reasons and almost all employees enroll in coverage, the distribution of risk in them is reasonably predictable and stable. Group risk becomes less predictable as a group becomes smaller and thus the concern of adverse selection increases. In the individual market, every applicant is considered an unmitigated adverse selection risk.

Insurers respond in two ways that drive up the cost of insurance and, as a result, price buyers out. First, insurers charge a higher premium based upon a rational presumption that higher-risk individuals will more often choose to purchase insurance than lower-risk individuals. This phenomenon is also called the “standard lemons pricing effect” . . . . Second, insurers counter adverse selection through risk selection and classification practices to the extent
permitted by state law, driving up overhead costs. For example, insurers use medical underwriting to design and price coverage based upon an individual’s projected risk. If a group or individual has high expected expenses, the insurer might charge a higher premium or limit coverage through exclusion of certain pre-existing conditions. If a person has already manifested an expensive disease, such as liver disease, the insurer might deny coverage altogether. Insurers also use sophisticated practices of marketing and benefit/network design to guide low-risk and high-risk beneficiaries to different insurance products. . . .

The use of such practices drives up administrative costs associated with insurance, resulting in higher load factors (administrative costs plus profits) in the small group and individual markets, where the risk of adverse selection is higher and these practices are more intensively used . . . . If the mandate does in fact eliminate adverse selection into markets by discouraging low-risk individuals from avoiding or dropping health insurance coverage, it might ameliorate some of this inefficiency. . . . Following a mandate, insurers can no longer assume that applicants are disproportionately lemons. Rationally behaving insurers in a competitive market would no longer charge “lemons” premiums, based on assumption of higher-than-average risk enrollees, thus making insurance affordable to more people. . . . That being said, . . . when certain practices for identifying risk are banned, insurers tend to rely on other practices – both legal and illegal – to identify higher-risk applicants. . . .
Initial Thoughts on Essential Health Benefits

Amy B. Monahan

NYU Review of Employee Benefits and Executive Compensation (2010)

While it does not grab the attention that the blockbuster reforms just described do, PPACA also requires that all health insurance policies issued on the individual and small group market cover “essential health benefits.” This change is a fundamental reform that will affect a great many Americans. For the first time, the federal government is taking the primary role in regulating the substance of health insurance coverage, at least in the individual and small group markets. And this task goes well beyond the limited substantive mandates contained in ERISA. The federal government will have to specify all of the services and treatments individual and small group policies must cover. Not only is the federal government broadening the types of policies it regulates by moving beyond the regulation of employer-sponsored coverage, it is also regulating a much broader range of services and treatments than it ever has before.

Interestingly, PPACA does not at all change the substantive regulation of large group plans, or of self-insured plans. Large group plans remain regulated at the state level and through ERISA, while self-insured plans remain subject only to ERISA’s limited substantive provisions. Despite the exemption for self-insured and large group plans, the definition of essential health benefits will be of primary policy importance given the large number of plans it will likely affect.

Essential health benefits are not, however, specified in the statute. Rather, the Secretary of HHS is directed to ensure that the scope of essential health benefits is “equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.” The statute also imposes significant boundaries on the Secretary’s ability to exclude benefits. In particular, the Secretary is directed to “[n]ot make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life” and also to “[e]nsure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.” There is no positive guidance regarding what should be the basis for excluding benefits, only what must not be used.

States continue to have the authority to regulate the substance of health insurance contracts, above and beyond the federal essential health benefit requirements. However, this authority is very significantly tempered. Because the federal government is subsidizing coverage obtained by low and moderate income individuals, PPACA provides that states must bear the cost of any premium increase caused by state benefit mandates that are greater than the federal essential health benefit requirements. This payment requirement applies only with respect to individuals who are receiving a premium tax credit through the exchange. Without such a requirement, states would be free to enact expensive benefit mandates and force the federal government to bear a significant portion of the cost of such mandate, because the federal tax credits are based on premium cost.

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Below is a table summarizing the various insurance markets and the permissible sources of substantive regulation that will be in place beginning in 2014, when the majority of PPACA’s insurance reforms take effect. As the table illustrates, instead of unifying and simplifying the substantive regulation of health insurance, PPACA has made it more complicated. . . .

**Sources of Substantive Regulation under PPACA**

<table>
<thead>
<tr>
<th>Market</th>
<th>Types of coverage available</th>
<th>Federal Regulation</th>
<th>State Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Exchanges</strong></td>
<td>Individual</td>
<td>Essential Health Benefits</td>
<td>States must subsidize mandates that exceed Essential Health Benefits for individuals receiving tax credits</td>
</tr>
<tr>
<td></td>
<td>Small Group</td>
<td>Essential Health Benefits + ERISA if employer-sponsored</td>
<td></td>
</tr>
<tr>
<td><strong>State Non-Exchange</strong></td>
<td>Individual</td>
<td>Essential Health Benefits</td>
<td>State may mandate additional benefits, no subsidy required</td>
</tr>
<tr>
<td></td>
<td>Small Group</td>
<td>Essential Health Benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Large Group</td>
<td>ERISA if employer-sponsored</td>
<td></td>
</tr>
<tr>
<td><strong>Self-insured Employer Plans</strong></td>
<td>Small Group</td>
<td>ERISA</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Large Group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Initial Thoughts and Questions**

PPACA’s provisions regarding the substance of health insurance coverage represent a tremendous change from the status quo, for the first time requiring the federal government to assume the primary role in this area of regulation. . . . The practical result is likely to be that states will no longer regulate the substance of health insurance in the individual and small group markets and will leave that task entirely to the federal government. . . .

Self-insured and large group plans do not need to concern themselves with federal essential health benefits because they are exempt from such requirements. At first glance, this is somewhat disconcerting. Much has been written regarding the unfairness of current health insurance regulation, where self-insured plans, even those that reinsure nearly all of the risk inherent in such plans, face essentially no substantive regulation while an employer that has chosen a different funding mechanism, direct insurance policy purchase, faces significant substantive regulation at the state level. . . . PPACA does little to address the regulatory disparity between insured and self-insured plans and in fact embraces self-insured and large group plans as market leaders to be emulated. . . .
One possible explanation is that it is preferable to have self-insured plans drive the regulatory market. Such an explanation would be premised on the assumptions that self-insured plans (1) are typically offered by large employers, which suggests that the employees covered by them may be a large enough group to be a fair representation of the community at large and (2) accurately reflect employee preferences with respect to the content of coverage. Unfortunately, there is reason to be skeptical that such plans do accurately reflect employee preferences. . . .

Perhaps the most interesting aspect of essential health benefits is the paucity of Congressional guidance given to the Secretary . . . [about] the basis on which the Secretary should exclude benefits from the definition of essential health benefits. Nearly all of the guidance given to the secretary is inclusionary in nature . . . . The decisionmaking process is going to be very difficult (and potentially very costly) without any such guidelines. Consider the fact that the determination of essential health benefits is subject to notice and comment. This means that individuals will have the opportunity to suggest which benefits to cover, and often these comments will be driven by personal anecdote. These anecdotes are very powerful. . . .

Unfortunately, if you look at the statute, it specifically denies to the Secretary the ability to use certain rationing mechanisms. For example, it prohibits the Secretary from making coverage decisions in ways that discriminate against individuals because of their expected length of life. This would presumably rule out the ability of the Secretary to deny coverage for an expensive cancer treatment that extends an individual’s life expectancy by only a few months, or to deny coverage for certain treatments for individuals of very advanced age. This provision appears to prevent the adoption by the Secretary of a scheme similar to that used in the United Kingdom, which is quantitatively based and takes into account such factors. While the approach has been criticized in the United States, it at least has the advantage of providing concrete guidelines on what gets covered and what does not. . . .

PPACA is a huge piece of legislation that will make many fundamental changes with respect to how health insurance is priced, bought, and paid for. Among these changes is a new role for the federal government in shaping the content of coverage, effectively displacing states in this area. This displacement is not particularly problematic if the federal government can do its job well. But the statute itself provides a tremendous amount of administrative authority to the Secretary of Health & Human Services with very little concrete guidance with respect to determining the content of such coverage. The most significant challenges faced by the Secretary are going to be creating a framework to make meaningful distinctions between benefits that are considered “essential” and those that are not, all while balancing the fiscal impact of such decisions.

8 The United Kingdom’s National Institute for Health and Clinical Excellence (abbreviated “NICE”) evaluates medical treatments and services on the basis of cost-effectiveness, calculating the cost per quality-adjusted life year gained by the treatment or service. In general, if a treatment costs more than £20,000 – 30,000 per quality-adjusted life year gain it is not considered cost-effective and often will not be covered. See National Institute for Health and Clinical Excellence, Measuring Effectiveness and Cost-Effectiveness: the QALY, www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenessstheqaly.jsp. See also Michael D. Rawlins & Anthony J. Culyer, NICE and its Value Judgments, 320 BMJ 224 (2004) (providing an overview of the NICE decisionmaking process).
Notes: Insurance Regulation and Reform

1. Constitutional Challenges. No one was surprised that the Supreme Court split 5-4 on the law’s constitutionality. What was surprising, though, were the two particular bases for the ruling. In all the litigation leading up to the Supreme Court, not a single lower court (out of the dozen or so) had ruled either that the mandate is merely a tax, or that the Medicaid expansion coerces the states unless they are allowed to opt out. Only time will tell whether these two qualifications will seriously compromise the law’s structure and likely effects.

Although the law survived (just barely), the Court applied two restrictions on federal powers that never before had been imposed: The commerce power may not be used to force people into commerce, and the spending power may not require a state to join a new federal program, no matter how generous it is, in order to maintain continued federal funding of an existing program the size of current Medicaid. Constitutional scholars will debate for years the broader significance of these rulings for other, non-health-care cases. Regarding the ACA’s constitutionality, additional resources and discussion are collected at http://acalitigationblog.blogspot.com/2011/06/some-essential-reading.html.

2. Controlling Costs without Rationing Care: Good Luck with That! The political aversion to acknowledging the inevitability of rationing care was amplified by the public uproar over the so-called “death squads,” falsely alleged (by Sarah Palin and other conservative opponents) to be part of health care reform proposals. The legislative provisos that preclude limiting care on account of costs were meant to dispel that bogeyman. Another political motivation was to minimize providers’ opposition to the legislation.

Initially, at least, the federal government has tossed this hot potato to the states, declaring that they should each decide how to meet the ACA’s requirement of 10 comprehensive “essential health benefits” while keeping insurance affordable: Essential Health Benefits: HHS Informational Bulletin (Dec. 2011), http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

2. Medical Loss Ratio. How to define and measure the “medical loss ratio” is a critically important and controversial policy issue because it entails the proper balance between administrative overhead and medical expenses. Consider, for instance, whether “wellness incentives” paid to patients for participating in weight reduction or health monitoring programs should count either in the numerator or the denominator. Are they a medical or administrative expense? Are they paid out of the premium, or do they instead act more like a premium rebate? See generally www.naic.org/documents/committees_e_hrsi_hhs_response_mlr_adopted.pdf

What strategies might emerge under these mandatory caps on overhead expenses? For a range of possibilities, consider the large fraud investigation of Wellcare, one of the country’s largest for-profit firms specializing in private Medicaid and Medicare plans. Wellcare agreed to pay almost $100 million to settle charges that (among other things), in order to meet Florida Medicaid’s 80% minimum loss ratio, it hid administrative expenses in an off-shore reinsurance subsidiary and in a wholly-owned mental health subsidiary, and that it manipulated payment rates to providers in order to exaggerate its actual medical expenditures. See http://securities.stanford.edu/1038/wcg_01/, http://hcrenewal.blogspot.com/search/label/Wellcare
3. **Insurance Exchanges and States’ Options.** The law’s major regulatory changes will not take effect until 2014. In the meantime, states must decide whether to establish their own insurance exchanges or instead to use a federal exchange as a default. Many of the same states that sued to invalidate the reform law on constitutional grounds also appear unlikely to have a state-based exchange in place by 2014, meaning that their citizens will be forced to use the fallback federal exchange. Is it consistent to claim that the law infringes states’ prerogatives to regulate health insurance, and at the same time abdicate to the federal government any state role in implementing insurance reforms?

In setting up either a federal or states insurance exchange, there are many important issues policy and regulatory issues to resolve. See Timothy S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (Commonwealth Fund, July 2010).

4. **ERISA Pre-emption, More Confusing than Ever.** Note that the reform law does not fundamentally rework the basics of ERISA pre-emption; instead, it adds another layer of complexity, in the form of exchange versus non-exchange markets. Within exchanges, it is not yet clear exactly how employer plans will be structured -- for instance, whether employers can select only one plan for all workers or instead must give workers a choice of plans to pick from.

States still may regulate insurance sold outside of exchanges, and still may not regulated self-insured employers. Also, ERISA continues to pre-empt state-law tort or contract suits against employer-sponsored plans, both inside and outside exchanges. The major change is that federal law now substantially fills in the ERISA regulatory “vacuum” created by ERISA pre-emption, as follows. It appears (but it is not yet 100% certain), that the following federal standards (some new, some existing) apply to self-insured employers as well as to insured plans:

- must cover pre-existing conditions, etc. (sec. 2704, 2712)
- may not exclude an entire category of licensed practitioners (sec. 2706)
- must cover participation in federally-funded or FDA-qualified clinical trials for life-threatening conditions (2709)
- must cover preventive health services (2713), at least 2 days following childbirth, and dependent children until age 26 (2714),
- must provide internal and external appeals processes for denied claims (sec. 2719)
- may not set lifetime or annual limits on total costs (sec. 2711)
- mental health parity (if mental health benefits are included, they may not have more limitations than regular health care)

The major remaining gap between ERISA pre-emption and federal law is the continuing absence under federal law of any personal injury damages against employer-sponsored health plans.

5. **Discrimination no More.** The provision discussed by Prof. Monahan above that prohibits designing essential benefits “in ways that discriminate against individuals because of their age, disability, or expected length of life” adds substantially to the ADA arguments discussed in the main casebook. According to Prof. Sara Rosenbaum (unpublished), this “powerful statutory check on . . . [benefits] design and plan administration has no counterpart in prior law.” Therefore, carefully note which types of insurance are (and are not) covered by this proviso.
III. HEALTH CARE DELIVERY REFORM

*Partners in Health: How Physicians and Hospitals Can Be Accountable Together*

Francis J. Crosson and Laura A. Tollen (2010)

Any approach to sustained cost reduction in health care must involve hospitals and physicians. Hospitalizations are the most costly form of care delivery, and conventional wisdom is that physician care decisions directly drive over 80 percent of total health care costs. Accordingly, there is a growing consensus that changes in payment incentives to hospitals and physicians are required, and that such changes must be more than superficial. Most such payment reforms involve either prepayment for services to be rendered, with some form of risk sharing, or episode-based payments such as case payments to physicians and hospitals together.

But there is a problem. As seen in [the Figure below], advanced payment methodologies are most feasible in an environment of highly organized providers. Such payment methodologies are much less feasible in the disaggregated delivery model that exists in much of the United States today.

**FIGURE 1.1 ORGANIZATION AND PAYMENT METHODS**

The solution to the problem is a coordinated set of delivery system reforms that involve changes in both payment and incentives and in the structure of how hospitals and physicians are organized to provide care. The changes must address the chicken-or-the-egg dilemma that has impeded progress in delivery system integration in many parts of the country. Without payment reform, there is little motivation for disaggregated physicians to do the hard work of forming larger organizations and to work with hospital administrators. Conversely, without the existence of greater numbers of integrated organizations, payers (including Medicare) have gained little

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traction in developing advanced payment methodologies because so few entities are capable of receiving them and succeeding with them.

Over the past eighty years, there have been a number of carefully constructed calls for delivery system integration. In 1933, the Committee on the Costs of Medical Care recommended that the United States seek to create many more group practices (modeled after the Mayo Clinic), because such practices were more efficient and less costly than solo practices. More recently, . . . in its landmark report in 2007, A High Performance Health System for the United States, The Commonwealth Fund Commission on a High Performance Health System called for “the U.S. [to] embark on the organization and delivery of health care services to end the fragmentation, waste, and complexity that currently exist. Physicians and other care providers should be rewarded, through financial and non-financial incentives, to band together into traditional or virtual organizations that can provide the support needed for physicians and other providers to practice 21st century medicine.”

The goal then, in the context of [the Figure above], is to move through both payment changes and delivery system changes over time from the “southwest” corner of the figure to somewhere closer to the “northeast” corner. There are many ideas about how to do this, discussed throughout this book. Virtually every one of these ideas for change will require increased collaboration or integration between hospitals and physicians. . . . Here, we will discuss three of these proposals: . . .

Clinical Integration

Most U.S. physicians practice medicine, at least in part, within a hospital setting but without a direct legal or financial relationship with the hospital. There are some exceptions to this model. In integrated delivery systems, such as Kaiser Permanente, . . . most physicians are employed by the group practice, which either owns or has a financial arrangement with the hospital or hospitals. Similarly, in physician hospital organizations (PHOs), the hospital and its associated physicians create a joint financial entity through which revenue is distributed. Recently, hospitals have begun to employ physicians directly in a variety of specialties. . . . In each of these settings, there is usually a sound structural, financial, and legal basis for physicians to work closely together to improve care quality and reduce unnecessary costs. . . .

In the more common setting, where the physicians and hospitals are not part of a single economic entity, the situation is quite different. In some states, the “corporate practice of medicine bar” prevents hospitals from hiring physicians . . . . In addition, a broad range of federal laws and regulations inhibits physician-hospital interrelationships, including antitrust provisions, tax-exempt organization regulations, laws intended to prevent limitation of services to Medicare beneficiaries, and “anti-kickback” and “Stark” provisions.

These regulations, as well as possible mitigation approaches, are discussed in detail [throughout this] Chapter. Were there to be a significant “relaxation” of the laws and regulations that now inhibit financial arrangements between otherwise separate physicians and hospitals, it is possible that more formal integrated structures . . . might be less necessary. However, the pace of such regulatory changes is likely to be too slow to foster the type of systematic reorganization that appears to be called for now, as part of health care reform. Therefore, other, more complex proposals are under consideration.
**Bundled Payments**

Currently, physicians and hospitals that are financially independent of each other are paid separately. . . . Thus, there is no financial incentive for the physicians to be efficient . . . . To address this problem, some payers have tried to combine payments to physicians and hospitals in a model known as *bundling*, or episode-based payments. . . . In the early 1990s, Medicare created the Medicare Participating Heart Bypass Center Demonstration, which bundled hospital and physician payments for cardiac bypass graft surgery. The payments covered readmissions within seventy-two hours postdischarge and related physician services for a ninety-day period. Although the demonstration was considered successful, it was not renewed because of opposition from some parts of the hospital industry. . . .

In its June 2008 report, MedPAC [the Medicare Payment Advisory Commission], having studied the issue for more than a year, made [these] unanimous recommendations to Congress regarding bundling [which Congress included in the 2010 health reform law]: . . . Congress should require the Secretary to create a voluntary pilot program to test the feasibility of actual bundled payment for services around hospitalization episodes for select conditions. . . . [T]he commissioners believed . . . that bundling could provide the incentive and opportunity for physicians to reduce the number of hospital visits without harming quality. Second, they intended that a bundled payment pilot would remove legal barriers that currently keep hospitals from compensating physicians for using fewer resources during a hospital stay. Third, depending upon the structure of the bundled payment, physicians would be encouraged to focus on posthospital care and the prevention of [hospital] readmissions. . . .

Whichever model proves to be the best, this type of incentive change is difficult. As noted by [MedPAC’s chairman], “we are] under no illusion that the path of policy change outlined here is easy. . . . But a continuation of the status quo is unacceptable.”

**Accountable Care Organizations**

. . . In 2006 [Elliot Fisher] and colleagues [at Dartmouth] proposed a solution to [the] problem [of limited numbers of integrated hospital and physician organizations]. 10 Noticing that most Medicare beneficiaries received most of their care from a single primary care provider and the hospital(s) in which that provider most often practiced, the authors proposed that integrated delivery systems could be created quickly by having payers “assign” patients to hospitals and their extended medical staffs based upon such usage patterns. They called the resulting virtually integrated system an accountable care organization (ACO). . . . [T]his book will use the term *accountable care organization* in a general sense to refer to the broad concept of an entity that is clinically and fiscally accountable for the entire continuum of care that patients may need, . . .

At the end of 2009 Congress seemed intent on creating robust pilot testing of ACOs and accompanying payment changes as part of [health care reform, which in fact it did in 2010]. . . . However Congress and the Secretary choose to support and implement ACOs in the future,

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physician-hospital integration will be required to make the model work. . . . As noted by Crosson, “a successful movement to the availability of ACOs will require substantial changes in how physicians and hospitals relate to and seek to integrate with each other. Integration must occur at the operational, financial, and cultural levels, each of which faces a number of barriers.”

Whether . . . integration driven by a more widespread use of bundled payments, or the evolution of ACOs, becomes the predominant reform dynamic in the next five or so years, there is little question that change is coming. . . . There are really only two ways to reduce [costs], either through progressive fee-for-service payment reductions to physicians and hospitals or through reorganization of care delivery and changes to payment and incentives. It is likely that only the latter choice has a simultaneous chance to improve quality. So the best hope is the most radical — to restructure and integrate.

But are U.S. physicians and hospitals capable of proceeding successfully through such changes? . . . Some remember all too well the failed attempts to “integrate” in the mid-1990s to prepare for managed care prepayment, which never materialized. Many nascent organizations failed or disbanded as a consequence. Hard feelings and financial losses were the result. Currently, in many institutions, physicians and hospitals are at loggerheads over control issues or are in frank competition for patients needing complex, profitable procedures. A first step in breaking down this negative environment is to analyze what is wrong and how it could be different. . . .

Notes: Medical Care Delivery; Provider Payment and Regulation

1. The Kitchen Sink. The new reform law is primarily about insurance coverage, and much less about health care delivery. It avoids mandating any major changes to the organization, regulation or payment of providers. Instead, it gently eases toward possible changes by funding various studies and pilot programs that will generate future recommendations. This is one reason it was supported, or not strongly opposed, by major provider organizations.

Nevertheless, the monumental bill is peppered with countless provisions affecting the organization and delivery of care. For instance (in no particular order):

- **Alternative providers.** In a sweeping move, the reform law (sec. 2706) flatly prohibits health plans (including self-insured employers) from “discriminating” against any category of licensed health care provider. Thus, insurers no longer may flatly exclude alternative providers, and it is debatable whether or to what extent they can set special conditions on payment for their services.

- **Generic biologics.** The law (sec. 7002) creates an expedited pathway for FDA approval of “biosimilar” versions of biological products, also called “biologics.” These are products such as vaccines, blood products, or those containing viruses or microorganisms

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that cannot easily be duplicated precisely. This expedited pathway previously was available only for non-biologic generic drugs.

- **Charitable tax exemption.** The reform law (sec. 9007) imposes new requirements for hospitals to maintain tax exemption. Starting in 2012, charitable hospitals must: 1) have clear written financial assistance policies that are widely publicized; 2) limit charges to patients eligible for financial assistance to no more than the lowest amounts that insurers pay; 3) avoid aggressive collection actions against patients who are eligible for and comply with the hospital’s financial assistance policy; 4) assess community health needs every three years and report annually how they address those needs and the reasons why any needs are not being addressed.

- **Fighting fraud.** It apparently is a law of nature that every major piece of health care legislation must increase the fight against health care fraud, and this one is certainly no exception. See John K. Iglehart, The ACA’s New Weapons against Health Care Fraud, New Eng. J. Med., June 30th, 2010, [http://healthcarereform.nejm.org/?p=3671](http://healthcarereform.nejm.org/?p=3671). With regard to the anti-kickback (referral fee) statute, the reform law (sec. 6402) states that "a person need not have actual knowledge of [this prohibition] or specific intent to commit a violation.”

2. **Innovation Without End.** The new Center for Innovation in CMS and the Independent Payment Advisory Board (IPAB) are expected to lead the way in developing, testing and disseminating new forms of provider payment that reward higher quality and lower costs. Both are focused on Medicare and Medicaid, but private insurers are expected to adopt the more successful approaches, and the structures that form for purposes of public insurance can also be used for private insurance. See generally Symposium, 29 Health Aff. 1284 (2010); Stuart Gutterman, et al., Innovation in Medicare and Medicaid Will be Central to Health Reform’s Success, 29 Health Aff. 1188 (2010); and the Crosson & Tollen book.

3. **ACOs: Here We Go Again.** While accountable care organizations (ACOs) appear destined to assume at least some prominence in the every-changing institutional landscape, at this point they are still just a concept and not an actual organizational structure. It is expected that ACOs will take multiple forms, similar to previous managed care organizations and alternative delivery structures reviewed in the casebook. Many of these existing templates are being dusted off and buffed up to respond to the new buzz. “The problem with this movie is that we’ve actually seen it before, and it was a colossal and expensive failure.” Jeff Goldsmith, The Accountable Care Organization: Not Ready For Prime Time, [http://healthaffairs.org/blog/2009/08/17/](http://healthaffairs.org/blog/2009/08/17/).

One important difference this time around is that ACOs are being conceived of in a “virtual” as well as “actual” form. A virtual form allows various unaffiliated providers to be held jointly accountable for a group of patients without their forming an actual corporate entity. Providers are linked based on naturally existing referral patterns among primary care physicians, specialists and area hospitals, and they receive incentive payments based on their collective performance. The structure is invisible to patients, who may still go to any doctor or hospital they want.

Although the literature allows for virtual ACOs, the initial pilot demonstration program authorized by the reform law (sec. 3022) requires that a legal entity exist that agrees to receive
and distribute the incentive payments. Called the “shared savings program,” this will continue to pay providers separately on a fee-for-service rather than bundled basis, but will award a collective bonus based on whether and how well a group of providers meets targets for cost savings without sacrificing measurable quality. The organization is responsible for patients who choose one of its primary care physicians, but they remain free to seek care wherever they want. The member providers decide how to share the bonus amongst themselves.

Under this initial incarnation of ACOs, Medicare will continue to pay providers separately on a fee-for-service rather than a bundled basis, but will allow ACOs to keep at least half of cost savings beyond benchmark targets, as long as they meet specific quality measures. Initial reactions to the rules have been subdued to negative, claiming that the potential rewards may not outweigh the business costs. Nevertheless, Medicare ACO formation might be legally advantageous because of the safe harbors that are conferred for antitrust, tax exemption, and referral fee laws. See generally


4. Medical Homes: Wouldn’t that be Nice. Short of full-scale integration across the spectrum of care, “medical homes” provide better integration of primary care and other out-patient services, especially for people with chronic illness. Medical homes are primary care physicians or clinics that provide a fuller spectrum of services, including a comprehensive medical record and coordinated referrals to necessary specialists. From one vantage, these are kinder and gentler versions of the primary care “gatekeepers” much reviled under the first generation of managed care. It is not clear, however, whether they have potential to save money since, at least initially, medical homes require more payment than ordinary primary care, in order to support their broader range of supporting services. As with other practice innovations, the health care reform law calls for medical homes to be studied and encouraged, but it fails to set a firm course. See generally Symposium, 25(6) J. Gen. Intern. Med. 584 (June 2010); Symposium, 27 Health Aff. 1218 (2008); Symposium, 67(4) Medical Care Res. & Rev. (Aug. 2010).

5. Calling All Lawyers. These various trends cause many observers to predict an upsurge in restructured relationships among doctors and hospital organizations. As with first-generation managed care, lawyers will need to consider a wide variety of legal, regulatory and reimbursement issues. Despite the reform law’s tentative support for various innovative structures for provider organization and payment, legal and policy ambivalence remains.

For instance, at the same time policy analysts are calling for more hospital/physician integration, the reform law (sec. 6001, eff. 2011) eliminates the exception for physician ownership of hospitals that previously existed under the Stark law’s prohibition of self-referral.
This exception had allowed physicians to practice in hospitals where they held an equity interest. (The new law grandfathers existing physician-owned hospitals, but only if they do not expand in size (with an exception for those that serve a large low-income population)). Also, the reform law left in place other legal doctrine that complicate affiliations among providers, such as the corporate practice of medicine doctrine and restrictions on “gainsharing.” Undoubtedly, then, there will be plenty of work ahead for health care lawyers to adapt organizational forms and contractual arrangements to the rapidly evolving environment.