COMMENTARY

PUTTING INSURANCE REFORM IN THE ACA'S REAR-VIEW MIRROR

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TABLE OF CONTENTS

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Insurance reform was supposed to be the easy part. It has not worked out that way.

I. HAVING IT ALL: INSURANCE REFORM, DELIVERY SYSTEM REFORM, AND PUBLIC HEALTH REFORM

It may have taken several decades for the stars to align, but the passage of the Patient Protection and Affordable Care Act (ACA) in early 2010 universalized (or nearly so) access to health insurance in the United States.[1] Several factors accounted for the ACA's passage. The Democratic Party controlled both the White House and Congress, with a filibuster-proof margin in the Senate (at least for the initial vote).[2] The Act's policy design, an individual mandate with decentralized funding and purchasing, drew ideologically on a longstanding proposal from a conservative think-tank and experientially on the Clinton Administration's deadly encounter in 1994 with the "tax-and-spend" consequences of federal fiscal accounting rules.[3] Most importantly, the suddenness and depth of the financial crisis in the late 2000s not only excused greater government involvement but also justified an infusion of federal funding sufficient to offset fears of redistributive losses and pay off key interest groups.

Enabled by these forces, the ACA solves on paper the twin problems that had long afflicted America's self-consciously nongovernmental health insurance system: that many individuals with substantial health care needs were deemed uninsurable by private carriers, and that a larger number of

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S.C.).

2. *Patient Protection and Affordable Care Act (PPACA)*, ENCYCLOPEDIA BRITTANICA ONLINE, http://www.britannica.com/EBchecked/topic/1673534/Patient-Protection-and-Affordable-Care-Act-PPACA (last visited Mar. 12, 2014).

3. Conor Friedersdorf, *Did a Conservative Think Tank Really Invent the Individual Mandate?*, ATLANTIC (Oct. 21, 2011), http://www.theatlantic.com/politics/archive/2011/10/did-a-conservative-think-tank-really-invent-the-individual-mandate/247124/; *see also A Detailed Timeline of the Healthcare Debate Portrayed in "The System,"* PBS NEWSHOUR, http://archive.is/vLiz (cached Sept. 7, 2012) (summarizing successful Republican efforts to quash Clinton's 1994 health care reform bill).

perfectly insurable individuals could not afford insurance. Protected by the individual mandate from adverse selection and tempted by new customers supported by federal tax subsidies for lower-wage workers, the health insurance industry watched the federal government wave its magic wand of nondiscrimination and declare the sick and impaired to be insurable. At the same time, the ACA poured even more dollars into expanding Medicaid coverage, almost entirely at federal expense, to all poor citizens and legal residents wherever located, replacing more restrictive and variable state-based criteria for designating the poor to be deserving of public assistance.[4]

But the ACA did not stop there. Titles I and II of the ten-section Act expand health insurance coverage.[5] Title III, called "Improving the Quality and Efficiency of Health Care," is about medical services and products rather than insurance, which is commonly if inelegantly termed "delivery system reform" by health policy experts.[6] The link between health insurance and health care is substantial, but the two are not coterminous. Insured individuals receive more, more timely, and more expensive care than uninsured individuals.[7] However, both groups frequently suffer inadequate, ineffective, or unsafe treatment, and the incremental benefits of health insurance to health care outcomes (both mortality and quality of life) remain challenging to quantify.[8] With over 15% of its population uninsured, moreover (pending full implementation of the ACA),

4. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) (2012) (providing new eligibility requirements for Medicaid); *id.* § 1396a(k) (requiring that individuals who meet the eligibility requirements receive a minimum level of coverage); *id.* § 1396d(y)(1) (explaining how much of the Medicaid expansion is at federal expense); *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-821, MEDICAID EXPANSION: STATES' IMPLEMENTATION OF THE PATENT PROTECTION AND AFFORDABLE CARE ACT 1–3, 6–7 (2012) (discussing the new eligibility requirements for Medicaid under the ACA).

5. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tits. I–II, 124 Stat. 119, 130–353 (2010) (codified as amended in scattered sections of 26, 29, 30, and 42 U.S.C.).

6. *See* Michael E. Porter, *A Strategy for Health Care Reform—Toward a Value-Based System*, 361 NEW ENG. J. MED. 109, 110–11 (2009) ("Although most U.S. health care reform efforts have focused on coverage, the far bigger long-term driver of success will come from restructuring the delivery system.").

7. *See The Uninsured: A Primer—Key Facts About Health Insurance on the Eve of Coverage Expansions*, HENRY J. KAISER FAMILY FOUND. (Oct. 23, 2013), http://kff.org/report-section/the-uninsured-a-primer-2013-4-how-does-lack-of-insurance-affect-access-to-health-care/.

8. Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1717–21 (2013); *see also* Bernard Black et al., *The Effect of Health Insurance on Near-Elderly Health and Mortality* 21–24 (Nw. Univ. Law Sch., Law and Economics Research Paper No. 12-09, 2013), *available at* http://ssrn.com/abstract=2103669 (presenting findings that health insurance neither significantly increases nor decreases health outcomes).

the United States spends nearly twice as much per capita on health care as any other nation, and there is little if any evidence that U.S. health care is superior in quality to countries that spend far less.[9] According to recent estimates, roughly $1 trillion is wasted each year on health care in the United States.[10]

Title IV of the ACA is called "Prevention of Chronic Disease and Improving Public Health."[11] Its focus is neither health insurance nor health care delivery, but underlying health. Whether at the individual or the population level, health care is not the major determinant of health.[12] Notwithstanding sharp, recent drops in tobacco use, the United States is notably unhealthy among developed countries, a fact borne out by its global rankings in basic indicators such as life expectancy at birth and infant mortality.[13] America's commitment to medical technology and heroic intervention pays dividends, though at considerable social expense, for individuals whose genes, behaviors, and socioeconomic circumstances have made them likely to reach advanced ages. For the broader population, however, chronic disease and associated impairment continue to increase, linked primarily to unhealthy lifestyles.[14] In 1985, adult obesity rates were under 15% in every state reporting data to the federal

9. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2012, at 22–25 (2013), *available at* http://www.census.gov/prod/2013pubs/p60-245.pdf; *see also* ORG. FOR ECON. CO-OPERATION & DEV., HEALTH AT A GLANCE 2013: OECD INDICATORS 24–25, 64–65, 88–89, 155–56 (2013) [hereinafter HEALTH AT A GLANCE], *available at* http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf (observing that despite the higher expenses, the United States has fewer doctors and hospital beds per person, and a shorter life expectancy at birth, than the OECD average).

10. INST. OF MED. OF THE NAT'L ACADS., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 13–14 (Mark Smith et al. eds., 2013); Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513, 1514 (2012).

11. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. IV, 124 Stat. 119, 538–88 (2010) (codified as amended in scattered sections of 21, 29, and 42 U.S.C.).

12. *See generally* WORLD HEALTH ORG., SOCIAL DETERMINANTS OF HEALTH (Richard Wilkinson & Michael Marmot eds., 2d ed. 2003) (arguing that a person's place in the social gradient has a major impact on lifelong health).

13. NAT'L RESEARCH COUNCIL & INST. OF MED. OF THE NAT'L ACADS., U.S. HEALTH IN INTERNATIONAL PERSPECTIVE: SHORTER LIVES, POORER HEALTH 26, 60 (Steven H. Woolf & Laudan Aron eds., 2013); HEALTH AT A GLANCE, *supra* note 9, at 24, 25 fig.1.1.1, 36, 37 fig.1.7.1; Steven H. Woolf & Laudan Y. Aron, *The US Health Disadvantage Relative to Other High-Income Countries*, 309 JAMA 771, 771–72 (2013).

14. *The Facts About Rising Health Care Costs*, AETNA, http://www.aetna.com/health-reform-connection/aetnas-vision/facts-about-costs.html (last visited Mar. 12, 2014).

Centers for Disease Control; in 2010, adult obesity rates in every state were over 20%, and in several states topped 30%.[15]

The ACA's true breakthrough—and its arguable overreach—is not its attempt to universalize health insurance, but its unprecedented goals of also making medical care better and more efficient and of improving underlying health.[16] This seemingly extraordinary ambition has a legitimate health policy pedigree. The nonprofit Institute for Healthcare Improvement (IHI), a pioneer in the quality and safety of medicine, describes the goals of changing health care as a "'Triple Aim': Improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost."[17] Moreover, IHI regards the three aims as mutually compatible and, given the current state of U.S. health care, eminently achievable.[18]

But these goals are still very difficult to accomplish in a single federal law. Unlike Titles I and II, there is no simple summary one can offer of the ACA's strategies for delivery system reform or population health improvement, or even metaphors to encapsulate them. Beyond the magic wand of insurability for the sick and disabled, beyond the mountains of money to make insurance affordable for those of limited means, images of solutions to suboptimal care and poor health offered by Titles III and IV are much harder to conjure than images of the problems that those parts of the ACA seek to address. A useful image for Title III is a ballpoint pen, symbolizing the well-intentioned but uncoordinated and cost-insensitive manner in which American physicians "order" nearly $2 trillion of medical

15. CTRS. FOR DISEASE CONTROL & PREVENTION, OBESITY TRENDS AMONG U.S. ADULTS BETWEEN 1985 AND 2010, *available at* http://www.cdc.gov/obesity/downloads/obesity_trends_2010.pdf; *see* J. Michael McGinnis & William Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207 (1993) (quantifying the behavioral factors responsible for clinical conditions that cause mortality).

16. *See* Barbara Peck, *Unprecedented Impact: Examining the Affordable Care Act*, ALL RISE, Winter 2014, at 40, 42 (observing the ACA's goals of improving affordability, lowering the uninsured rate, and reducing health care costs); Kathleen Sebelius, *Improving the Public's Health Through the Affordable Care Act*, U.S. DEP'T HEALTH & HUMAN SERVS. (Sept. 11, 2013), http://www.hhs.gov/healthcare/facts/blog/2013/09/improving-public-health.html (discussing the ACA's "unprecedented resources" devoted to supporting "community-based strategies to prevent chronic diseases, and to improve public health").

17. *The IHI Triple Aim*, INST. FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/offerings/initiatives/tripleaim/pages/default.aspx (last visited Mar. 12, 2014).

18. *See id.* (describing how all three dimensions of the triple aim should be addressed and how the United States can improve in many areas of health reform by implementing the triple aim strategy).

services and products each year.[19] A useful—and similarly shaped—image for Title IV is the fast-food french fry, symbolizing the mass-marketed, on-demand, high-caloric density, low-physical-activity lifestyle that has accompanied suburban sprawl and American demographic and economic change.[20]

The pen and the french fry constitute the two critical challenges for health reform beyond health insurance. Given the complexity of addressing each of these areas, one might think that the scope and staging of the ACA's triple ambition would have been subjected to intense political scrutiny and sustained public debate. This did not happen. Neither the feasibility nor the fiscal prudence of making concurrent changes to coverage, care, and health was ever seriously discussed. Opposition to the ACA was—and remains—fiercer than one might have anticipated based on the history of health care regulation. But rather than pragmatic objections, the passions aroused were strongly partisan and ideological, and the closest attention was reserved for supposed features of "Obamacare" that had emotional resonance, such as "government takeovers" and "death panels."[21]

This Commentary acknowledges and applauds efforts to understand the mechanisms of insurance reform contained in the ACA and to evaluate their success or failure.[22] But the Commentary's principal purpose is to examine the pros and cons of connecting insurance reform to health care and health—the pen and the french fry—and to convey the importance to the country of moving beyond insurance reform as quickly as possible. The Commentary begins by describing the potential synergies among the three health policy domains and offering reasons why the ACA sought to make simultaneous changes. It

19. Physicians' decisions about diagnostic testing, hospitalization, referrals for other services, medications, and other treatments account for a much larger percentage of health care spending than their fees alone. Anne B. Martin et al., *National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year*, 33 HEALTH AFF. 67, 73–74 (2014).

20. Reid Ewing, Ross C. Brownson & David Berrigan, *Relationship Between Urban Sprawl and Weight of United States Youth*, 31 AM. J. PREVENTIVE MED. 464, 470 (2006).

21. Benjamin W. Corn, *Ending End-of-Life Phobia—A Prescription for Enlightened Health Care Reform*, 361 NEW ENG. J. MED. e63(1), e63(1)–(2) (2009), http://www.nejm.org/doi/pdf/10.1056/NEJMp0909740 (discussing the "death panel" controversy and the fears that fuel it); Frank Luntz, *The Language of Healthcare 2009: The 10 Rules for Stopping the "Washington Takeover" of Healthcare*, THINKPROGRESS 1 (2009), http://thinkprogress.org/wp-content/uploads/2009/05/frank-luntz-the-language-of-healthcare-20091.pdf (contending that "[n]othing else turns people against the government takeover of healthcare than the realistic expectation that it will result in delayed and potentially even denied treatment, procedures and/or medications").

22. *See, e.g.*, Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 HOUS. L. REV. 1029 (2014).

then identifies the vulnerabilities that are revealed in the Act's combined approach. It concludes with a few observations about ways of improving both health care delivery and health, while expressing the hope that the ACA's indisputably sweeping ambition will not be its downfall.

II. INSURANCE AS THE PATH TO EFFICIENT CARE AND BETTER HEALTH

When insuring 85% of the U.S. population costs nearly twice as much per capita as any other country pays to cover its entire citizenry, adding the remaining 15% to the insurance pool without ironclad guarantees of cost containment would seem like a bad bet.[23] Heightening this concern is the apparent randomness of American medicine, in which both the need for particular care and the quality of the services provided are strikingly variable.[24] Otherwise, phrases such as "throwing bad money after good" come quickly to mind.

Indeed, government health entitlements (Medicare and Medicaid) already comprise the most rapidly growing category of federal expenditures, which the United States has been able to accommodate without large tax increases in recent years only because of historically low borrowing costs and long-term secular decreases in military spending.[25] State governments, which are restricted in their ability to incur debt to fund current operations and have limited tax revenue, have seen Medicaid costs leapfrog first higher education and then kindergarten through twelfth-grade education.[26] The increasing costs are setting up a destructive competition for public investment not only between younger and older generations, but between two key generators—education and health—of "human capital" and therefore a productive workforce.

In an ominous sign, federal discretionary spending on everything except national defense has dropped below its

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23. DENAVAS-WALT, PROCTOR & SMITH, *supra* note 9, at 68; HEALTH AT A GLANCE, *supra* note 9, at 154–56.

24. *See* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, 2012 NATIONAL HEALTHCARE DISPARITIES REPORT 1, 3 (2012), *available at* http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf (focusing on disparities in healthcare between geographical regions, ethnicities, and socioeconomic groups and cataloging healthcare inefficiencies that occur when unnecessary treatments are performed).

25. D. ANDREW AUSTIN, CONG. RESEARCH SERV., RL 34424, TRENDS IN DISCRETIONARY SPENDING 21 (2014); D. ANDREW AUSTIN & MINDY R. LEVIT, CONG. RESEARCH SERV., RL 33074, MANDATORY SPENDING SINCE 1962, at 9, 10 fig.2 (2012).

26. *See* THE STATES PROJECT, THE STATE OF THE STATES REPORT 2012, at 15–16 (2012), *available at* http://www.thestatesproject.org/wp-content/uploads/2012/Full_Report.pdf (remarking on the recent growth in Medicaid spending).

longtime benchmark range of 3% to 3.5% of GDP, indicating a potentially serious budgetary strain on government. Nor has the private sector been spared. Premium increases for private health coverage, which in the United States is predominantly obtained through employment, persistently crowd out cash raises in annual decisions about compensation packages for workers.[27] An aging population with worsening health from rapid rises in serious chronic conditions such as diabetes, cardiovascular disease, and cancer accentuates these trends in health care expenditures.[28]

Based on these statistics, one would imagine cost control to be "job one" for health reform, with a stepwise strategy to defer additional outlays until the current system proved itself capable of demonstrating its value proposition and restraining its most inflationary tendencies. At a minimum, it seems that any increase in publicly funded health insurance coverage would be made contingent on matching the expense of the health care systems much more closely to its performance. One might also reasonably think that any coverage expansion would be integrated into a long-term plan to improve population health and moderate the human and financial consequences of chronic disease.

These characteristics accurately describe the ACA's organizational framework, but not its operational details. Why not? Three categories of explanation present themselves. First, the ACA adheres closely to an established path for U.S. health reform called "managed competition" that dates back to the Nixon Presidency but had its fullest flowering in the Clinton Administration's failed Health Security Act.[29] Because it is designed around large prepaid organizations, managed competition posits that overall costs will be lower if there is universal or near-universal participation in insured systems. Second, the ACA largely assumes that the funds currently circulating in the health care system are not only sufficient to finance universal coverage but also are more likely to be spent efficiently if everyone is insured on an equal footing. This reasoning reflects a belief that inertia in the current system is

27. David I. Auerbach & Arthur L. Kellermann, *A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family*, 30 HEALTH AFF. 1630, 1631 (2011).

28. Thomas Bodenheimer, Ellen Chen & Heather D. Bennett, *Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job?*, 28 HEALTH AFF. 64, 65 (2009).

29. DAVID BLUMENTHAL & JAMES A. MORONE, THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE 356–64 (2009).

primarily the result of uncertainty over funding and that making implicit commitments and expectations more explicit will improve performance. Third, and relatedly, the ACA is captive to its political history both within the Democratic Party and at the federal level more generally. This history associates reform with a social safety net for unanticipated risks of hardship, presumes that demand for services is valid and unmet, and pays little attention to re-engineering the systems of care that supply those needs.

A. Managed Competition

"Managed competition" denotes a health care system design in which the government structures and monitors competition among private health insurers to deliver covered services at market prices.[30] It is usually contrasted with "single-payer" systems of national health insurance, in which the government acts as sole insurer and pays health care providers directly for covered services, usually at administratively determined rather than competitive rates.[31] Managed competition was first articulated in the late 1980s by two California health policy academics, Alain Enthoven and Richard Kronick, who extended ideas developed for President Nixon's Comprehensive Health Insurance Plan, which (unlike the Federal HMO Act of 1973) did not survive Nixon's resignation.[32]

In the early 1990s, managed competition seemed a centrist alternative to Ted Kennedy's single-payer liberalism and therefore became the basis for President Clinton's Health Security Act.[33] President Obama made a similar political calculation, thereby importing into the ACA a policy construct that pursues universal coverage by remaking private insurance markets more than by extending public insurance programs. The effect is to entrust the quality and efficiency of care and, to some

30. *See* David DeGrazia, *Single Payer Meets Managed Competition: The Case for Public Funding and Private Delivery*, HASTINGS CENTER REP., Jan.–Feb. 2008, at 23, 25 (noting that under a managed competition plan the federal government organizes and manages the insurance system in which insurance companies compete to provide insurance to individuals).

31. *See* P. Hussey & G.F. Anderson, *A Comparison of Single- and Multi-Payer Health Insurance Systems and Options for Reform*, 66 HEALTH POL'Y 215, 215, 217 (2003) (explaining that under single-payer systems, the government creates an annual budget to determine the total amount of health care expenditures).

32. Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 NEW ENG. J. MED. 29 (1989).

33. *See* Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Jan. 1993, at 24, 46.

extent, even the improvement of health to insurance-based entities.

1. Competing on Care. Several elements of managed competition, at least in theory, align coverage with health care and health. First, much of the management in managed competition has, as its goal, channeling insurers into competing on the care they deliver, not the actuarial risk they bear.[34] On the supply side, insurers—as under the ACA—must issue and renew policies, may not exclude individuals or limit coverage based on health status, and are limited in their ability to adjust their price to account for risk.[35] Insurers are protected from potentially adverse consequences of these restrictions by mandatory participation in the risk pool and by mechanisms to risk-adjust the payments they receive (rather than the premiums they charge).[36] On the demand side, consumer choice is limited to plans offering standardized benefits that can be compared based on cost and measurable quality of care delivered.[37] The objective of these constraints is to encourage thinking about health insurance as the provision and purchase of prepaid health care rather than financial protection against large, unexpected losses.

2. Group Purchasing. Active purchasing is the heart of managed competition, typically by groups rather than individuals.[38] Group insurance is actuarially more predictable, enabling a focus on care rather than risk and making quality measurement more statistically meaningful. The ACA's insurance "exchanges" and "marketplace" are descended from Enthoven and Kronick's health insurance purchasing cooperatives, which morphed into "health alliances" in the Clinton Health Security Act, which in turn begat the "connector" used in the Massachusetts health reform of the mid-2000s.[39] The

34. *See id.* at 25, 29 (stating that under the managed competition model, insurers are rewarded for improving quality and satisfying patients, not for reducing risk).

35. *See id.* at 31 (discussing features of managed competition systems).

36. *See* 42 U.S.C. § 18091 (2012) (determining that the individual mandate will reduce the cost associated with caring for the uninsured); *id.* § 18061 (providing payments to health insurers that insure "high risk" individuals).

37. *See* Enthoven, *supra* note 33, at 32.

38. *See id.* at 29 (noting that managed competition must involve active purchasing agents purchasing plans on behalf of large groups).

39. *Id.* at 35 (describing health insurance purchasing cooperatives); *see* DEMOCRATIC POLICY & COMMC'NS. CTR., THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: DETAILED SUMMARY, *available at* http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf (describing the ACA health exchange); Chelsea Conaboy, *Mass. Health Connector Fraught with Uncertainty*, BOS. GLOBE (Jan. 9, 2014), http://www.bostonglobe.com/lifestyle/health-wellness/2014/01/09/despite-fixes-some-left-

concept's political appeal has depended on terminology and philosophy; most purchasing pools downplay regulation in favor of competition and centralized control in favor of mutual assistance. However, getting a good deal for subscribers still requires savvy management that can leverage volume to lower prices and assure quality, much as the largest employers have been doing for their workers for over twenty years. For this reason, managed competition has often been associated with health reform proposals that use an employer mandate to expand coverage, maintaining reliance on the existing system of employer-sponsored health insurance.[40]

3. Taxability of Health Benefits. In addition to group purchasing leverage, most managed competition proposals have sought to improve the cost-effectiveness of health care by eliminating or substantially limiting the federal tax subsidy that employer-sponsored health coverage has long enjoyed.[41] Unlike cash wages, workers do not pay income tax on the value of health insurance provided as a fringe benefit of employment, which currently costs the federal treasury roughly $250 billion annually in forgone revenue.[42] As a result, employers have spent far more on health insurance, and therefore health care, than would be the case in an efficient market. The ACA acknowledged this strategy by declaring money spent by employers on certain "Cadillac health plans" to be taxable income to workers, but maintained the vast majority of tax preferences for group health insurance.[43]

4. Organized Systems of Care. Managed competition is not synonymous with managed care, but proposals to universalize private health insurance have generally contemplated a leading role for "good" managed care organizations that improve the efficiency and cost-effectiveness of health care delivery.[44] It has long been

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uncertain-about-connector-health-insurance-coverage/L8gzHXCTV4QiM2CTdiV8JI/story.html (noting that the Massachusetts connector runs the state's insurance marketplace).

40. *See, e.g.*, Enthoven, *supra* note 33, at 42.

41. *See, e.g.*, Health Security Act, S. 1757, 103d Cong. § 7201(b) (1993) (limiting the federal tax subsidy for employer-sponsored health plans).

42. 26 U.S.C. § 106(a) (2012) (excluding employer-provided health care coverage from gross income); CONG. BUDGET OFFICE, THE DISTRIBUTION OF MAJOR TAX EXPENDITURES IN THE INDIVIDUAL INCOME TAX SYSTEM 6 (2013), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf.

43. Bradley Herring & Lisa Korin Lentz, *What Can We Expect from the "Cadillac Tax" in 2018 and Beyond?*, 48 INQUIRY 322, 322–23 (2012).

44. Enthoven, *supra* note 33, at 37, 41 (providing examples of organized systems of managed care that are successful and cost-effective).

appreciated that medical care in the United States is fragmented and reactive, often neglecting prevention and early treatment in favor of higher-cost salvage at later stages of disease. In particular, the American convention of basing care around community hospitals whose medical staffs are open to independent private practitioners has created a physician class with specialized, expensive practice habits, often idiosyncratic ones, that hospitals have had little incentive or ability to discourage.[45] These failings of health care delivery are thought to be compounded by traditions of fee-for-service provider reimbursement, with separate payment streams for health professionals and for health facilities.[46] The positive outliers have often been large group practices such as the Permanente Medical Group in California, the Mayo Clinic in Minnesota, and the Geisinger Clinic in Pennsylvania, many of which operate on a prepaid basis with dedicated facilities as closed-panel health maintenance organizations (HMOs).[47] Organizations of this type have a predicted advantage under managed competition because of their emphasis on care coordination, prevention, and timely treatment, but it has long been assumed that large commercial health insurers would follow their lead if the incentives were right.[48]

5. Community Health Investment. If health insurance becomes the province mainly of large organizations that compete on the efficiency of care, the delivery model shifts from individual health to managing the health of enrolled populations.[49] This transition in mission has become more urgent, and more likely, because of recent, rapid increases in chronic disease burden.[50] The underlying causes of the most common and serious health

45. *See id.* at 38 (suggesting that the traditional fee-for-service model has left the current health care system with an excess supply in many specialties).

46. MAURA CALSYN & EMILY OSHIMA LEE, CTR. FOR AM. PROGRESS, ALTERNATIVES TO FEE-FOR-SERVICE PAYMENTS IN HEALTH CARE 1, 6 (2012), *available at* http://www.americanprogress.org/wp-content/uploads/2012/09/FeeforService4.pdf.

47. Richard Kronick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148, 149 (1993) (citing the Permanente Medical Group as an example of an efficient competitor); Thomas H. Lee, Albert Bothe & Glenn D. Steele, *How Geisinger Structures Its Physicians' Compensation to Support Improvements in Quality, Efficiency, and Volume*, 31 HEALTH AFF. 2068, 2068–69 (2012) (describing Geisinger's successful physician payment program under a fee-for-service arrangement).

48. *But see* Charles N. Kahn III, *Payment Reform Alone Will Not Transform Health Care Delivery*, 28 HEALTH AFF. 216, 217 (2009) (supporting the inference that the model adopted by the Mayo clinic is successful because of its capacity and integration).

49. *See* Enthoven, *supra* note 33, at 39 (discussing how organized systems can be held accountable for their enrolled populations' prevention of chronic diseases).

50. Bodenheimer, Chen & Bennett, *supra* note 28, at 65 & exhibit 2, 66.

conditions such as heart disease, kidney failure, diabetes, and cancer are predominantly behavioral (e.g., tobacco use, poor diet, inadequate physical activity), and preventive intervention at the community level is essential.[51] Managed competition models therefore contemplate insurance organizations investing substantially in community health improvement, connecting coverage not only to more efficient care but also to better underlying health.[52]

B. Reshuffling Resources

Expanding coverage can help address the problems of the pen and the french fry through mechanisms additional to changes in the nature of health insurance associated with managed competition. These arguments tend to be less wedded to theories of health system design, and instead they engage pragmatically with the realities of providing care to people who cannot afford it, most of whom are currently uninsured. From this perspective, universal or near-universal coverage will help rationalize both demand for health care and its supply, enabling the health care system to reshuffle existing resources to serve more people at lower cost.[53] Implicit in this perspective is the assumption that U.S. wage earners, taxpayers, and policyholders are already providing a substantial degree of funding for people other than themselves and the inference that such money could be spent more effectively and efficiently.

1. Cost-Shifting. A central premise of the argument that covering the uninsured will not hugely increase health care costs is that we are already paying for them in higher insurance premiums for those with private coverage, which in turn reflect higher prices charged to insurers by hospitals and physicians.[54] According to this reasoning, the charitable impulses and obligations of health care providers—whether derived from professional ethics, unfunded government mandates, or the tacit

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51. *See generally* COMM. ON HEALTH & BEHAVIOR, HEALTH AND BEHAVIOR: THE INTERPLAY OF BIOLOGICAL, BEHAVIORAL, AND SOCIETAL INFLUENCES (2001), *available at* http://www.ncbi.nlm.nih.gov/books/NBK43743/pdf/TOC.pdf.

52. *See* Enthoven, *supra* note 33, at 39 (explaining how organized systems under managed competition "emphasize prevention, early diagnosis and treatment, and effective management of chronic conditions").

53. *See id.* at 41–42 (arguing first that universal coverage is required to make managed competition work and second that managed competition is the best way to reduce national health expenditures).

54. *See* KATHLEEN STOLL & KIM BAILEY, FAMILIES USA, HIDDEN HEALTH TAX: AMERICANS PAY A PREMIUM 6 (2009), *available at* http://www.familiesusa.org/sites/default/files/product_documents/hidden-health-tax.pdf.

preference of "society" that the poor not die visibly from treatable illness—generate bills that must be paid by somebody else, and that are therefore passed through to paying customers as a share of overhead. There is more than a little ambiguity, if not illogic, to this position. Are health care markets so uncompetitive, or demand so inelastic, that providers with charitable impulses are able to force consumers to bear the associated costs? What explains the large sums of money flowing to health care suppliers with few, if any charitable obligations, such as pharmaceutical companies? Still, it seems plausible that substantial redistribution of health care resources occurs implicitly at the provider level, and that increasing explicit redistribution by expanding formal coverage would serve as a partial substitute for it.

2. Distorted Prices. The high and seemingly arbitrary level of provider prices, especially for hospital care, is a very visible difference between the United States and other developed nations.[55] Those other countries also provide universal coverage, which the United States lacks pending full implementation of the ACA. A possible connection between the two is that the need for cross-subsidization at the provider level of care for the uninsured distorts prices compared to what would prevail in a competitive market.[56] If this is true, those distortions—likely highly variable—could plausibly impair the efficiency of private purchasing decisions. Distortions in hospital billing may arise not only from the fact of cross-subsidization, but also from arcane and entrenched pricing practices necessary to draw revenue from multiple contributing sources.[57] Universalizing coverage could help prices return to competitive levels, reducing waste and enhancing value for buyers.

3. Expensive Care Settings. It is often observed that uninsured patients are cared for in ways that are unnecessarily

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55. Ezra Klein, *21 Graphs That Show America's Health-care Prices Are Ludicrous*, WASH. POST: WONKBLOG (Mar. 26, 2013, 12:40 PM), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/03/26/21-graphs-that-show-americas-health-care-prices-are-ludicrous/; *see also* Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, HEALTH AFF., May/June 2003, at 89, 90, 91 exhibit 1, 92.

56. *See* STOLL & BAILEY, *supra* note 54, at 6 (concluding that insurance companies inflate premiums to recover costs associated with caring for the uninsured). There are, of course, alternate explanations for international price differentials, including political mobilization to keep spending down, supply constraints for specialized services and new technologies, and direct price controls.

57. *See* Elisabeth Rosenthal, *As Hospital Prices Soar, a Stitch Tops $500*, N.Y. TIMES, Dec. 3, 2013, at A1 (attributing distorted and arbitrary hospital care billing to "little or no price regulation in the private market").

costly.[58] The poster child for this phenomenon is the emergency department (ED) of an inner-city hospital, where fees charged to private pay patients tend to be extraordinarily high.[59] Uninsured patients may seek care in EDs for three reasons: the ED is legally obligated to care for them regardless of their ability to pay, they may forgo care because of cost concerns until their illness is too severe to be treated elsewhere, and there may be few alternative providers located in the poor neighborhoods where they live.[60] Expanding coverage, therefore, may both enable demand for lower-cost care settings and increase their supply. The ED overuse example is salient with the public because most everyone has been to an ED and thinks of them as too crowded and too costly, but the potential savings from reducing ED use by the poor are likely exaggerated, at least in the short term.[61] EDs must remain fully staffed and supplied in case of unexpected need, so that the marginal cost of treating a simple problem in the ED is far less than the average cost.[62] In addition, ED bills tend to be particularly inflated so that hospital charges greatly overstate the real resource cost of emergency care.[63]

4. Prevention and Early Treatment. ED overuse is one part of a broader argument that covering the uninsured will improve the efficiency of the care they receive. In contrast to critics of insurance who emphasize the inflationary risks of moral hazard, universal coverage advocates see insurance as empowering

58. *See, e.g.*, STOLL & BAILEY, *supra* note 54, at 4–5 (observing that an uninsured person's medical condition often becomes exacerbated because medical treatment is delayed until the condition becomes serious); Enthoven, *supra* note 33, at 41 (noting that millions of uninsured Americans often receive care in "costly settings" as opposed to lower-cost settings like a primary care physician's office).

59. *See* Deval Shah-Canning, Joel J. Alpert & Howard Bauchner, *Care-Seeking Patterns of Inner-City Families Using an Emergency Room: A Three-Decade Comparison*, 34 MED. CARE 1171, 1172, 1177 (1996) (recognizing that emergency rooms have "fulfilled a vital role in meeting health-care needs for inner-city families").

60. 42 U.S.C. § 1395dd(b) (2012) (requiring hospitals to treat any person seeking emergency medical care, regardless of whether that individual is eligible for health insurance); STOLL & BAILEY, *supra* note 54, at 4–5; RENEE M. GINDI, ROBIN A. COHEN & WHITNEY K. KIRZINGER, CTRS. FOR DISEASE CONTROL, EMERGENCY ROOM USE AMONG ADULTS AGED 18–64: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–JUNE 2011, at 2 (2012), *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf.

61. *See* Sarah L. Taubman et al., *Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment*, 343 SCIENCE 263, 267–68 (2014).

62. Anil Bamezai, Glenn Melnick & Amar Nawathe, *The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume*, 45 ANNALS EMERGENCY MED. 483, 484 (2005).

63. Rosenthal, *supra* note 57.

patients to access necessary services on a timely basis.[64] They observe that insurance coverage includes preventive care, often at no cost to the enrollee, and believe that earlier treatment is generally cheaper treatment.[65] Although expanding the option set for the currently uninsured should indeed improve the subjective value they derive from health care, it is not clear how often prevention or early treatment reduces overall medical expense.[66] For example, cost–benefit analyses of mass screening tests almost never show net savings.[67] To save money, early interventions should be targeted at high-risk individuals.[68] Of course, preventative services nonetheless may be beneficial to recipients, and may even be cost-beneficial to society if the accounting of their benefits extends beyond the health care domain and the discount rate applied to future savings is not too high.[69]

5. Administrative Costs. A point of pride for single-payer advocates has been the low administrative costs of government-run health insurance programs, particularly abroad but also with respect to Medicare. Risk-selection activities, marketing and advertising, and profitability are among the avoidable costs often cited by skeptics of private insurance models.[70] Most health policy experts have concluded that wasteful provision of clinical care greatly exceeds wasteful insurance administration in the United States, but the latter is not trivial.[71] A transition to a

64. *See* Douglass Farnsworth, *Moral Hazard in Health Insurance: Are Consumer-Directed Plans the Answer?*, 15 ANNALS HEALTH L. 251, 253–54 (2006) (describing the existence of moral hazard in the context of health insurance); *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 JAMA 798, 799 (2003) (advocating for a universal national health insurance program where every American would be covered for all medically necessary services).

65. *See* ROSS DEVOL & ARMEN BEDROUSSIAN, MILKEN INST., AN UNHEALTHY AMERICA: THE ECONOMIC BURDEN OF CHRONIC DISEASE 183–85 (2007), *available at* http://www.milkeninstitute.org/pdf/chronic_disease_report.pdf (predicting reduced expenses and improved productivity as a result of prevention).

66. *See generally* Louise B. Russell, *Preventing Chronic Disease: An Important Investment, but Don't Count on Cost Savings*, 28 HEALTH AFF. 42 (2009) (suggesting that prevention adds to medical expenses rather than reducing them).

67. *See* Joshua T. Cohen, Peter J. Neumann & Milton C. Weinstein, *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 661 (2008).

68. *Id.*

69. *See* NAT'L PREVENTION COUNCIL, DEP'T OF HEALTH & HUMAN SERVS., NATIONAL PREVENTION STRATEGY 51 (2011) (enumerating the economic benefits of prevention).

70. *Id.* at 49–50; Susan Adler Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 LAW & INEQ. 1, 16 (2010).

71. *See* INST. OF MEDICINE OF THE NAT'L ACADS., BEST CARE AT LOWER COST 3 (2012), *available at* http://www.iom.edu/~/media/Files/Report%20Files/2012/Best-Care/

better coordinated program, still administered through private insurers but channeled into certain activities, was seen by the ACA's supporters as having the potential to reduce administrative expense and increase resources available for the uninsured. For example, the Act sets minimum levels for insurers' "medical loss ratios"—a counterintuitive term that means the amount of the premium dollar spent on care rather than profit or administration.[72] It also obligates insurers to clear significantly rising rates with state insurance regulators or the federal government, presumably to invite scrutiny of the justifications for those increases.[73]

6. Labor Markets. Universal health insurance may increase general economic productivity as well, which is another policy argument for coverage expansion despite its potential health care costs. In the long term, one would hope that an insured population would be healthier, which would reduce absenteeism and improve workplace performance. These benefits remain speculative, however. More concretely, tying insurability to employment in existing private coverage arrangements results in demonstrable labor market inefficiencies. An example is "job lock": individuals who prefer other jobs may not move because doing so would risk loss of insurability based on their health or the health of their dependents.[74]

C. Politics and Government

Several of the most straightforward explanations for the Obama Administration's decision to grapple simultaneously with coverage expansion, cost control, and health improvement are political. These include historical path dependence of various types: partisan, ideological, and structural.[75] They also include more theoretical or conceptual considerations

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Best%20Care%20at%20Lower%20Cost_Recs.pdf (recommending continuous improvement in health care operations to reduce waste and eliminate inefficiencies).

72. Hall, *supra* note 22, at 1048–49.

73. 42 U.S.C. § 300gg-94 (2012).

74. Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, HEALTH AFF., Nov./Dec. 1999, at 124, 127; *see also* Paul Krugman, Op-Ed., *Why Do You Care How Much Other People Work?*, N.Y. TIMES (Feb. 10, 2014, 11:00 AM), http://krugman.blogs.nytimes.com/2014/02/10/why-do-you-care-how-much-other-people-work/?_php=true&_type=blogs&_r=0.

75. *See* Simon F. Haeder, *Beyond Path Dependence: Explaining Health Care Reform and Its Consequences*, POL'Y STUD. J., Apr. 2012, at 65, 66 ("Many of the explanations of the historic development of the American healthcare system brought forward by health policy scholars emphasize the role of path dependence to one degree or another.").

regarding the ways in which American government should influence and assist the provision of health care.[76]

1. Social Insurance. Universal health coverage has been perceived as the missing piece of the nation's social safety net since the New Deal, and it cannot be coincidental that its long-delayed passage happened just after the United States experienced an economic downturn second in severity only to the Great Depression.[77] Like the Social Security and Medicare programs, the ACA and its predecessor health reform efforts were framed as a collective commitment to protect against potential hardship—what has been called "us-us" thinking—rather than an openly redistributive model designed to aid the less fortunate.[78] This immediately categorized the ACA as an insurance initiative on par with the national health insurance programs of the social democracies in Canada and Western Europe, some of which operate through private sickness funds.

2. Lack of Stepwise Alternatives. With the exception of the Nixon Presidency, health reform has been owned exclusively by the Democratic Party. Most Republican administrations have offered symbolic changes at best, and several have pushed back against existing entitlement programs in favor of privatization.[79] Although partisan rancor and ideological purism seem particularly rampant these days, there was no precedent during the ACA debate for a program that combined serious cost controls with coverage expansions, except perhaps for the much more limited effort to enact a Medicare prescription drug benefit under President George W. Bush.[80] This was particularly true because a social insurance approach required a perception of broad advantage, implying

76. *See* President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009) (transcript available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care) (noting, in introducing the Affordable Care Act, that the government's role must be carefully balanced).

77. *See* John Holahan, *The 2007–09 Recession and Health Insurance Coverage*, 30 HEALTH AFF. 145, 146, 152 (2011) (describing the impact of the 2007–2009 recession and encouraging health care reform to create an expanded social safety net).

78. Theodore R. Marmor & Jerry L. Mashaw, *Understanding Social Insurance: Fairness, Affordability, and the 'Modernization' of Social Security and Medicare*, 25 HEALTH AFF. w114, w117 (2006).

79. BLUMENTHAL & MORONE, *supra* note 29, at 19.

80. Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071–152 (2003) (setting forth Medicare prescription drug benefits).

that existing health insurance benefits could not be very visibly restricted.[81]

3. Federal Hammers and Nails. An old saying, often applied to surgeons during medical training, observes that if all one has is a hammer, everything looks like a nail. In the U.S. federal system, the established division of authority over health care places government insurance programs mainly at the federal level and regulation of health professions, health facilities, and public health mainly at the state level.[82] There are exceptions: state regulators monitor private health insurance (though state authority over employer-based health coverage has been significantly reduced by the federal ERISA statute), and the Food and Drug Administration (FDA) oversees drugs and medical technologies.[83] In general, however, the federal government influences the efficiency and effectiveness of health care services primarily by its approach to paying for services covered by Medicare and Medicaid. This made it even more intuitive for the ACA to contemplate health care cost containment and clinical quality improvement only in the context of an insurance-based program. An important qualification is that the ACA's reliance on individual purchasing from private carriers in decentralized exchanges makes it harder to regulate through payment policy, which partially explains why the Act's delivery system reform initiatives focus on Medicare.[84]

4. A National Challenge. Universalizing coverage was a clear signal that health reform was a national problem requiring a national solution. The ACA conveyed solidarity, if not

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81. *See* Sam Gutterman, *The Nature of Social Insurance Programs and Their Funds*, SOC'Y OF ACTUARIES, http://www.soa.org/Professional-Interests/Social-Ins/Nature-of-Social-Insurance-Programs.aspx (last visited Mar. 12, 2014) (explaining that social insurance results in coverage of a large part of the population).

82. The most well-known examples of federal insurance programs being Medicare and Medicaid, created by the Social Security Amendments of 1965. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (setting forth Medicare provisions in Title 18 and Medicaid provisions in Title 19).

83. *See* Carolyn McClanahan, *Should States Really Regulate Health Insurance?*, FORBES (June 19, 2012), http://www.forbes.com/sites/carolynmcclanahan/2012/06/19/should-states-really-regulate-health-insurance/ (describing state regulation over insurance companies); *U.S. Food and Drug Administration Home Page*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/AboutFDA/CentersOffices/default.htm (last visited Mar. 12, 2014).

84. *See* JAMES R. HORNEY & PAUL N. VAN DE WATER, CTR. ON BUDGET & POL'Y PRIORITIES, HOUSE-PASSED AND SENATE HEALTH BILLS REDUCE DEFICIT, SLOW HEALTH CARE COSTS, AND INCLUDE REALISTIC MEDICARE SAVINGS 1, 5 (2009), *available at* http://www.cbpp.org/files/12-4-09health.pdf (explaining that a large number of the proposals for restructuring delivery systems underlying the ACA involved Medicare).

uniformity, primarily through the individual mandate to purchase insurance with standardized benefits and the regularization of Medicaid eligibility requirements among states.[85] Considered prospectively from the perspective of the Obama Administration and the Democratic Congress, these interventions also may have seemed more familiar and less likely to provoke controversy than any effort led by the federal government directly to reduce health care spending, improve the quality of care, or enhance public health.

III. UNANTICIPATED OBSTACLES TO INSURANCE REFORM

As the preceding discussion demonstrates, there was method in the Obama Administration's decision to forge ahead with a major coverage expansion and associated insurance reform in the ACA notwithstanding the looming disasters of spendthrift health care and deteriorating health. But there may also have been madness. Reforming insurance has become much harder than anticipated, with the expansions of both private and public coverage that ACA proponents took for granted experiencing substantial delays and complications. Some of these, such as the poor performance of the healthcare.gov website in handling online enrollment, undercut confidence in the competence of government.[86] Others, such as President Obama's ill-conceived "promise" that nobody would lose existing coverage, undercut perceptions of the government's honesty.[87] Furthermore, each problem the ACA is experiencing now foreshadows even more difficult battles to come over both health care and health.

It is easy, and largely accurate, to blame the toxic political climate in which American government currently operates. Republicans have been obstructionist in ways that would have been unimaginable for the minority party after the passage of Medicare in the 1960s.[88] But Democrats, and the Obama Administration in particular, have failed utterly to explain the goals or contents of the ACA to the public and have let their opponents define the debate. Missteps in the roll out of the insurance exchanges, for example, could have been moderated if not wholly avoided by a better program of communication. As a

85. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 18091 (2012).

86. Robert Pear, Sharon LaFraniere & Ian Austen, *From the Start, Signs of Trouble at Health Portal*, N.Y. TIMES, Oct. 13, 2013, at A1.

87. Michael D. Shear & Robert Pear, *Obama in Bind Trying to Keep Health Law Vow*, N.Y. TIMES, Nov. 13, 2013, at A1.

88. Michael D. Shear, *A Rollout's Stumbles Draw Parallels to Bush*, N.Y. TIMES, Nov. 15, 2013, at A1.

result, roughly half the states have acted in ways that no Democrat in Washington, D.C., would have considered rational when the ACA was passed.[89] This, in turn, has greatly increased the risk that individuals will reject or ignore their obligations and opportunities under the Act, and that what could easily have been a decisive victory in the expansion of health coverage will become a war of attrition.

*A. The Supreme Court (*National Federation of Independent Business v. Sebelius*)*

The ACA's "With Friends Like These" award goes to the United States Supreme Court. In a 5–4 decision with Chief Justice Roberts as the swing vote, the Court in *National Federation of Independent Business v. Sebelius* upheld the constitutionality of the ACA, rejecting arguments that its central provisions exceeded federal authority under Article I.[90] In doing so, however, it made both of the ACA's major coverage expansion initiatives "optional," while failing to credit the Act with any overarching national purpose, policy logic, or structural integrity.[91]

Five conservative justices opined that mandating the private purchase of insurance was not authorized as regulation of interstate commerce, but the Chief Justice joined the four more liberal members to hold that congressional tax power permitted the government to impose a penalty for not purchasing insurance.[92] Moreover, all of the conservatives emphasized that

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89. *See State Decisions for Creating Health Insurance Marketplaces, 2014*, HENRY J. KAISER FAMILY FOUND., http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ (last visited Mar. 12, 2014) (reporting that twenty-seven states have opted not to create and run their own insurance exchanges); *Status of State Action on the Medicaid Expansion Decision, 2014*, HENRY J. KAISER FAMILY FOUND. [hereinafter *Status of State Action on the Medicaid Expansion*], http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last visited Mar. 12, 2014) (reporting that as of 2014 nineteen states had not yet opted to implement the Medicaid expansion).

90. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2598–600, 2608–09 (2012).

91. *See* William M. Sage, *How Many Justices Does It Take to Change the U.S. Health System? Only One, But It Has to Want to Change*, HASTINGS CENTER REP., Sept.–Oct. 2012, at 27, 28–29 (noting that the Court's holding renders both the individual mandate and Medicaid expansion optional).

92. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2593, 2600 (demonstrating the liberal justices' concurrence with Chief Justice Roberts's characterization of the mandate as a tax, but not with his holding that the individual mandate was not a valid exercise of Congress's Commerce Clause power); *id.* at 2644 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (demonstrating the conservative justices' concurrence with the holding that the individual mandate was not a valid exercise of Congress's Commerce Clause power).

federal overreaching was not only an affront to state sovereignty, but was also a threat to individual liberty.[93] Thus a civic obligation to participate in a national system of coverage became merely a modest tax on remaining uninsured.[94]

With respect to the Act's other major provision, the Court ruled 7–2 that it was unconstitutionally coercive for the ACA to "offer" states the Medicaid expansion on pain of losing all federal funding if they refused, but again the Chief Justice anchored a slim majority upholding the provision if only new funding associated with the expansion were put at risk.[95] Thus the Court declared a generous subsidy to support the working poor to be an instrument of federal oppression, while sheltering the "resistance" from even the threat of reprisal.[96]

Of equal symbolic concern was that all five conservative justices dismissed the ACA's policy design, which they regarded as a politically driven mishmash of subsidies and requirements.[97] Only Justice Ginsburg's concurrence, in which the four liberals supported the individual mandate on several constitutional grounds, credited the Act with any inherent logic or cohesiveness among its sections.[98] But even the concurrence failed to connect the ACA's insurance reforms with its delivery system or public health reforms, or to acknowledge that the law had core purposes beyond expanding coverage.[99]

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93. *Id.* at 2578 (majority opinion); *id.* at 2676–77 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).

94. *See id.* at 2608 (majority opinion) ("[I]t is reasonable to construe what Congress has done as increasing taxes on those who have a certain amount of income, but choose to go without health insurance. Such legislation is within Congress's power to tax.").

95. *See id.* at 2603–04 (demonstrating Justices Roberts, Breyer, and Kagan's finding of unconstitutional coercion); *id.* at 2643, 2662 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (demonstrating Justices Scalia, Kennedy, Thomas, and Alito's finding of unconstitutional coercion); *id.* at 2607 (majority opinion) (demonstrating Justices Roberts, Breyer, and Kagan's upholding of Congress's ability to withhold new Medicaid funds provided by the ACA from noncompliant states); *id.* at 2630–31, 2642 (Ginsburg, J., concurring in part and dissenting in part) (demonstrating Justices Ginsburg and Sotomayor's agreement that Congress can withhold new Medicaid funds provided by the ACA from noncompliant states).

96. *See id.* at 2603–04 (majority opinion) (holding that denial of existing Medicaid funds to noncompliant states is unconstitutional coercion).

97. *See id.* at 2591–93 (rejecting the argument that the mandate is an "integral part of a comprehensive scheme of economic regulation" (internal quotation marks omitted)); *id.* at 2676 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (complaining that "Congress . . . must take as its point of departure a jumble of now senseless provisions").

98. *See id.* at 2609, 2613 (Ginsburg, J., concurring in part and dissenting in part) (asserting that Congress achieved a "practical, altogether reasonable, solution" in passing the ACA).

99. *See id.* at 2609–42.

The Supreme Court's lukewarm endorsement of the ACA emboldened states with conservative leanings to resist implementing the Act's insurance provisions.[100] Doing so exposed weaknesses in the ACA's drafting that cannot presently be remedied through legislation because the necessary votes are lacking. Democrats never imagined that states would reject the Medicaid expansion, which initially would be funded entirely at federal expense and which would always be more generously supported from Washington, D.C., than the traditional Medicaid program.[101] Texas, for example, stands to lose at least $70 billion over a ten-year period, which would finance coverage for over one million low-income residents who are currently supported by local resources.[102] As a result, the ACA does not offer tax subsidies for Medicaid-eligible individuals to access the insurance exchanges in states that refuse the expansion, even though these individuals earn less than other subsidized purchasers.[103] Yet, as of December 11, 2013, only twenty-five states and the District of Columbia had decided to expand Medicaid, while twenty-three states were not doing so and two states continued to debate the question.[104]

Similarly, congressional supporters of the ACA assumed that all states would choose to operate their own insurance exchanges

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100. *See id.* at 2608 (majority opinion) ("As a practical matter . . . States may now choose to reject the expansion . . . ."); Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 85 (2013) ("In states that exercise their *NFIB* Red State Option to not expand adult [Medicaid eligibility], we have a new healthcare 'donut hole.' The poorest adults will still have Medicaid under current law, but to widely varying levels of eligibility." (footnote omitted)); *Status of State Action on the Medicaid Expansion*, *supra* note 89 (reporting that as of 2014, nineteen states had not yet opted to implement the Medicaid expansion).

101. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (asserting that "Congress never dreamed that any State would refuse to go along with the expansion of Medicaid"); CTR. ON BUDGET & POLICY PRIORITIES, STATUS OF THE ACA MEDICAID EXPANSION AFTER SUPREME COURT RULING 1, 4, (2013), *available at* http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf (noting that the federal government currently covers about 57% of all states' Medicaid spending, but will cover 100% of the costs of expansion during the first three years and will cover 90% of the costs beginning in 2020).

102. ANNE DUNKELBERG, CTR. FOR PUB. POLICY PRIORITIES, MEDICAID EXPANSION RESOURCE GUIDE: ALL THE LATEST ON THE COSTS AND BENEFITS FOR TEXAS 2 (2013), *available at* http://www.forabettertexas.org/images/HC_2013_02_PP_MedicaidExpansion.pdf; TEX. COMPTROLLER OF PUB. ACCOUNTS, DIAGNOSIS: COST—AN INITIAL LOOK AT THE FEDERAL HEALTH CARE LEGISLATION'S IMPACT ON TEXAS 21 (2010), *available at* http://www.window.state.tx.us/specialrpt/healthFed/hr3590Cost.pdf.

103. Carter C. Price & Christine Eibner, *For States That Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments*, 32 HEALTH AFF. 1030, 1035 (2013).

104. *Status of State Action on the Medicaid Expansion*, *supra* note 89.

because it would assure them control, with considerable flexibility, over the cultures and practices of those organizations.[105] The ACA even provides federal financial assistance for states to use when establishing their own exchanges.[106] Instead, as of February 15, 2014, only fourteen states were operating their own exchanges, with seven states using federal–state partnerships and thirty-six states (including Texas) deferring entirely to federal facilitation, which was included in the ACA only as a backstop.[107] This unanticipated burden on the Centers for Medicare and Medicaid Services to organize and broker health insurance enrollment in much of the United States is one of the reasons why the federal website has experienced so many difficulties.[108] Moreover, opponents of federal health reform have argued that the law's text does not permit the Internal Revenue Service (IRS) to administer tax subsidies for federally facilitated exchanges.[109]

B. Choice and Liberty

As the Supreme Court's decision presaged, the ACA's insurance reforms have encountered a surprising degree of resistance based on perceived tensions between constrained choice and personal liberty.[110] The American medical profession

105. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) ("If Congress had thought that States might actually refuse to go along with the expansion of Medicaid, Congress would surely have devised a backup scheme so that the most vulnerable groups in our society, that those previously eligible for Medicaid, would not be left out in the cold. But nowhere in the 900-page Act is such a scheme to be found."); *see also* David K. Jones, Katharine W.V. Bradley & Jonathan Oberlander, *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. HEALTH POL. POL'Y & L. 97, 99, 111 (2014) (noting that forty-eight states initially applied for an exchange planning grant and that health insurance exchanges were seemingly uncontroversial, as they allowed states "the flexibility to determine their structure, governance, and level of regulation").

106. 42 U.S.C. § 18043 (2012).

107. *State Actions to Address Health Insurance Exchanges*, NAT'L CONFERENCE OF STATE LEGISLATURES (Feb. 15, 2014), http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx.

108. *See* Roberta Rampton, *Days Before Launch, Obamacare Website Failed to Handle Even 500 Users*, REUTERS (Nov. 21, 2013), http://www.reuters.com/article/2013/11/22/us-usa-healthcare-website-idUSBRE9AL03K20131122.

109. Complaint at 12–13, Halbig v. Sebelius, No. 13-0623 (PLF), 2013 WL 5786889 (D.D.C. Oct. 22, 2013); Brief of Jonathan H. Adler and Michael F. Cannon as Amici Curiae in Support of the Plaintiffs at 3–10, Halbig v. Sebelius, No. 13-0623 (PLF), 2013 WL 5786889 (D.D.C. Oct. 22, 2013).

110. Robert E. Moffit, *Obamacare and the Individual Mandate: Violating Personal Liberty and Federalism*, WEBMEMO (Heritage Found., Washington, D.C.), Jan. 18, 2011, at 5, 5–6, *available at* http://thf_media.s3.amazonaws.com/2011/pdf/wm3103.pdf (citing Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 788 (E.D. Va. 2010), *vacated*, 656 F.3d 253 (4th Cir. 2011)).

has long promoted free choice by patient of physician and by physician of patient as a bedrock principle of health policy.[111] In the 1990s, insurance industry opponents of the Clinton Administration's reform proposal successfully transferred public angst over choosing one's doctor to choosing one's insurer as well, probably because the latter was seen as a proxy for the former.[112] This rhetoric has escalated in debates over implementing the ACA. It has also been given a constitutional gloss that it previously lacked, most clearly in challenges to the ACA from both individuals and corporations who claim that the mandatory inclusion of contraceptive services in the standardized benefit packages infringes their religious liberties.[113]

In retrospect, the centrality of concerns over personal liberty, in coverage as well as care, is attributable at least in part to the Obama Administration's decision to construct the ACA around an individual mandate to purchase insurance, with the employer mandate to offer coverage that had been foremost in earlier reform proposals relegated to a backstopping role.[114] Placing the principal onus on individuals rather than employers reduced the ACA's vulnerability to chamber of commerce arguments about economic burden and job loss, but enhanced the impact of libertarian rhetoric as government-imposed incentives, requirements, and restrictions became more visible to the public, rather than being largely shielded from view by employer intermediation. As a practical matter, the shift from employed groups to individual enrollment—even though most private

111. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 23–24 (1982) (discussing ideal market conditions that allowed sellers and buyers to choose freely without being forced to accept certain terms, and the medical profession's attempt to control market forces); Charles D. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1358–59 (1984) (explaining the prior American structure of health care delivery as market free choice plans that allowed for consumers to choose providers based on price and nonprice considerations).

112. *See generally* Raymond L. Goldsteen et al., *Harry and Louise and Health Care Reform: Romancing Public Opinion*, 26 J. HEALTH POL. POL'Y & L. 1325 (2001) (analyzing the Health Insurance Association of America's campaign against the Clinton Administration's health care reform proposal).

113. *See* Hobby Lobby Stores, Inc. v. Sebelius, 870 F. Supp. 2d 1278 (W.D. Okla. 2012), *rev'd and remanded*, 723 F.3d 1114 (10th Cir. 2013), *cert. granted*, 134 S. Ct. 678 (2013); *see also* Conestoga Wood Specialities Corp. v. Sebelius, 917 F. Supp. 2d 394 (E.D. Pa. 2013), *aff'd sub nom*. Conestoga Wood Specialties Corp. v. Sec'y of U.S. Dep't of Health & Human Servs., 724 F.3d 377 (3d Cir. 2013), *cert. granted*, 134 S. Ct. 678 (2013).

114. The ACA provides an individual mandate that requires "applicable individual[s]" to obtain health insurance by 2014 or otherwise become subject to a tax penalty. 26 U.S.C. § 5000A(a)–(c) (2012). Though the focus is on the individual mandate, the ACA lists both individual and employer responsibilities. *See* 26 U.S.C. § 5000A (outlining the various requirements relating to the individual mandate); 29 U.S.C. § 218a (describing automatic enrollment for employees of large employers).

coverage will still be accessed through the workplace over the next few years—also increased the risk that adverse selection will compromise the viability of the insurance exchanges if healthier individuals decide to pay a modest tax instead of enrolling.[115]

The individual mandate intensified the Obama Administration's need to reassure the public that the ACA would facilitate future choices and not compromise past ones with which people are satisfied. Economists disagree about the prevalence of "loss aversion," but resistance to change is a natural phenomenon in government and politics.[116] Because trust is an essential aspect of medical care, moreover, the process of receiving treatment often converges with the outcome of that treatment in patients' perception of quality.[117] This makes health care particularly susceptible to wishful thinking and the Lake Wobegon syndrome, in which nearly all patients come to regard their own care arrangements as significantly above average.[118] With respect to the ACA's insurance reforms, it also painted the administration into a corner. The President promised that individuals could keep their existing coverage if they wished, but he could not control the decisions of insurers to continue to offer that coverage in a competitive marketplace.[119]

Privacy—being unmonitored by the government and unrevealed to others without one's consent—is another important aspect of the libertarian's prized right to be left alone. The coverage expansion necessarily entails the collection and sharing

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115. *See* CONG. BUDGET OFFICE & JOINT COMM. ON TAXATION, CBO AND JCT'S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE 4 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf (describing the decrease in employer-based health insurance coverage); NAT'L ASS'N OF INS. COMM'RS, ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT 1 (2011), *available at* http://www.naic.org/store/free/ASE-OP.pdf (explaining how employer-based health insurance coverage minimizes the risks of adverse selection).

116. NICCOLÒ MACHIAVELLI, THE PRINCE 24–25 (W.K. Marriott trans., Constitution Society 1908) (1515) ("And it ought to be remembered and there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things.").

117. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 949 (1963) (explaining that, in medical care, the product and the activity of production are identical and contain an essential element of trust).

118. DAVID DRANOVE, CODE RED 91 (2008); SANDRA WILDE, TESTING AND STANDARDS 45 (2002).

119. President Barack Obama, Remarks by the President at the Annual Conference of The American Medical Association (June 15, 2009) (transcript available at http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association).

of considerable personal information, and breaches of data security are an ever-present risk. Early security audits of the healthcare.gov website have not been reassuring. Nor is the public particularly comfortable with the ACA's obligation to convey personal information to insurers, who are generally mistrusted even though their incentives to exploit information for corporate gain are considerably attenuated by the ACA's restrictions on medical underwriting and pricing-to-risk.[120] Perceptions of threats to privacy are worsened by the involvement of the IRS in enrollment processes involving the insurance exchanges. Though necessary to administer subsidies for low-income individuals and families, IRS participation both adds another party traditionally regarded with hostility to those with potential access to personal health information and subjects sensitive financial data to the risk of compromise. Suspicions created in connection with the ACA's coverage expansion therefore may be heightened if and when more private information is sought to improve the efficiency of health care delivery or the improvement of underlying health.

That the public has been so sensitized to issues of choice and liberty as the ACA's coverage expansion is implemented does not bode well for the critical conversations that will be necessary to reduce wasteful care and improve underlying health. Allegations of rationing, "death panels," and the "nanny state" lurk around every corner, and virtually nothing has been done to educate the public about the strategies that insurers and providers will need to adopt as delivery system reform proceeds.[121] Media exposure of hospital overpricing has resurfaced, supplementing the staple criticisms of greedy insurers and drug companies.[122] But the

120. *See* 45 C.F.R. § 155.320 (2012) (authorizing the disclosure of protected health information).

121. *See* Paul Hsieh, Op-Ed, *The Dangerous Synergy Between the Nanny State and Universal Health Care*, FORBES (June 18, 2012), http://www.forbes.com/sites/realspin/2012/06/18/the-dangerous-synergy-between-the-nanny-state-and-universal-health-care/; *Kaiser Health Tracking Poll: April 2013*, HENRY J. KAISER FAMILY FOUND. (Apr. 30, 2013), http://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013/; Neil Macdonald, *The Nanny-State Lie Behind Obamacare*, CBC NEWS (Nov. 4, 2013), http://www.cbc.ca/news/world/the-nanny-state-lie-behind-obamacare-1.2325696; Peter Ubel, *Why It Is So Difficult to Kill the Death Panel Myth*, FORBES (Jan. 9, 2013), http://www.forbes.com/sites/peterubel/2013/01/09/why-it-is-so-difficult-to-kill-the-death-panel-myth/.

122. The public rejected the Clinton Administration's healthcare reform proposal in the early '90s. James P. Pfiffner, *President Clinton's Health Care Reform Proposals of 1994, in* TRIUMPHS AND TRAGEDIES OF THE MODERN PRESIDENCY 69, 70–71 (David Abshire ed., 2001). *See generally* HEALTH AFFAIRS, HEALTH POLICY BRIEF 1, 3, 5 (2012), *available at* http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_78.pdf (discussing the evolution of managed care and the emphasis on quality and pay-for-performance features); *What Is ObamaCare/What Is Health Care Reform?*, OBAMACARE

political classes have yet to grapple with the realities of managed care as it has evolved from the restrictive version that was soundly (if perhaps unwisely) rejected by the public in the 1990s to its current incarnation as a physician-led, patient-centered project that emphasizes quality measurement, price transparency, and pay-for-performance.[123] The phrase "managed care" is hard to find in ACA guidance—it is nearly absent from the healthcare.gov website—and it is seldom to be heard in health policy debates even when discussion turns to delivery system reform ideas such as Accountable Care Organizations that are its direct descendants.

C. Fairness and Redistribution

Central to a social insurance model for health reform is to conceptualize universal coverage as a collective investment in mutual assistance rather than a compelled transfer of resources from the better-off to the less fortunate. The existing Medicare program meets this condition only because aging is inevitable, and today's contributors will be tomorrow's beneficiaries (at least in theory). With respect to private coverage, all of the currently insured participate willingly in some risk pool—typically the workforce of a common employer—within which redistribution occurs. Workers and their families are not similarly situated in terms of health risks and do not know one another personally except in small workplaces, but accept their shared circumstances as natural and desirable. The ACA's insurance reforms seek to replicate this acceptance on a national scale.

At present, some of the loudest objections to the fairness of the ACA's insurance reforms are being voiced by a small number of participants in existing individual insurance markets who feel that they have made prudent decisions to buy less coverage than the new law requires, and who now find those policies being cancelled by the insurers as ACA noncompliant.[124] Many of these

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FACTS, http://www.obamacarefacts.com/whatis-obamacare.php (last visited Mar. 12, 2014) (explaining the features and goals of the Affordable Care Act).

123. *See Sticker Shock: Investigating the High Costs of Hospital Bills*, ABC NEWS (Nov. 20, 2013, 7:30 PM), http://www.abcnews.go.com/blogs/health/2013/11/20/sticker-shock-investigating-the-high-costs-of-hospital-bills/.

124. *See, e.g.*, Ariana Eunjung Cha & Lena H. Sun, *For Consumers Whose Health Premiums Will Go Up Under New Law, Sticker Shock Leads to Anger*, WASH. POST (Nov. 3, 2013), http://www.washingtonpost.com/national/health-science/for-consumers-whose-health-premiums-will-go-up-under-new-law-sticker-shock-leads-to-anger/2013/11/03/d858dd28-44a9-11e3-b6f8-3782ff6cb769_story.html (discussing criticisms and providing examples of those who purchased individual insurance and were subsequently forced to pay more for unwanted services as a result of the ACA); Avik Roy, *Obama Officials in 2010: 93 Million Americans Will Be Unable to Keep Their Health Plans Under*

individuals espouse conservative political views and have more confidence in markets than in government. They object not only to losing their own desired coverage, but also to subsidizing insurance for others who, in their view, may be prone to moral hazard and tempted to overuse or waste resources.

The key health policy question is whether the higher-deductible coverage that is being lost is worth preserving, particularly considering that the ACA's insurability strategy depends on healthier and less healthy people sharing the same risk pools. Proponents of high-deductible policies sometimes conflate a consumer's individually rational economic response to rapidly rising costs for more complete coverage with the less-than-transparent sale of an inadequate product to people who may not notice the inadequacy until it is too late.[125] Which is a more accurate depiction of high-deductible coverage depends on context; there is no clean line dividing policies that offer lower premiums and incentivize policyholders to spend prudently on care from policies that exploit people's tendency to ignore or underestimate unpleasant contingencies.[126] The ACA's standards for acceptable coverage are therefore negotiable, particularly with respect to deductibles and cost sharing, and should be adjusted if needed to preserve the public's sense of overall fairness.

Resistance to redistribution has also been reflected in the reaction to the ACA's tax provisions. Taxes can be used as policy instruments both to raise revenue and to change behavior, and the ACA contains a mix of taxation strategies.[127] However, the American public tends to resist tax increases as unfair regardless of purpose, and U.S. politicians will seldom support them. As

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Obamacare, FORBES (Oct. 31, 2013), http://www.forbes.com/sites/theapothecary/2013/10/31/obama-officials-in-2010-93-million-americans-will-be-unable-to-keep-their-health-plans-under-obamacare/ (noting that 40%–67% of individually purchased insurance plans will lose their grandfather status and become illegal, forcing insurers to offer services that are neither demanded nor needed).

125. *See* James R. Knickman, *The Downside of High-Deductible Health Plans*, HUFFINGTON POST BLOG (Oct. 11, 2013, 12:11 PM), http://www.huffingtonpost.com/james-r-knickman/the-downside-of-highdeduc_b_4079460.html (explaining the benefits and pitfalls of high-deductible health plans to include encouraging consumer consciousness in healthcare spending but also risking consumers forgoing needed care).

126. *See* CONG. BUDGET OFFICE, CONSUMER-DIRECTED HEALTH PLANS: POTENTIAL EFFECTS ON HEALTH CARE SPENDING AND OUTCOMES 1, 45, 52 (2006), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/77xx/doc7700/12-21-healthplans.pdf.

127. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2596–97, 2600 (2012) (explaining that the ACA tax will not only raise revenue but will also affect individual conduct); Robert D. Cooter & Neil S. Siegel, *Not the Power to Destroy: An Effects Theory of the Tax Power*, 98 VA. L. REV. 1195, 1204–06 (2012) (explaining how methods to promote general welfare may involve regulatory means, including taxes).

noted above, the ACA boosted the taxability of employer-sponsored health benefits only minimally, essentially punting on an intervention widely supported by health policy experts that would have both raised revenue and inserted a modicum of cost-consciousness into insurance design. Continuing controversy over the insurance expansion has eroded any political cover for taxation that its supporters might have enjoyed; for example, the ACA's tax on medical devices (which are substantially overpriced and overused) is under attack and may soon be repealed.[128] This antipathy is likely to carry over to tax strategies that might be proposed to improve health, such as surcharges on unhealthy behaviors, even though the Supreme Court's holding affirmed the permissibility of such an approach as a constitutional matter.[129]

The worst casualty of contentious insurance reform is any nascent sense of social solidarity around health care and health that the passage of the ACA might have nurtured. In other developed countries, health solidarity is an important social value that not only maintains support for universal coverage, but it also enables the polity to resist special interests whose demands for resources, if satisfied, would threaten the system's sustainability for the general population. The British, for example, act collectively as voters to restrain the potential for excessive spending in the National Health Service in part because they realize that, as patients, it is hard to restrain their impulse to have the system spend too much.[130] The United States has never bred a collective politics of health care capable of reining in special interests, as our high health care spending attests.[131] Among other things, there is little political mobilization to refute the common misperception, routinely encouraged by special interests, that employment growth in the health care sector is good for the general economy.[132]

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128. *See* Devin Leonard, *Why the Medical Device Tax Came to Rule the Debt-Ceiling Talks*, BUSINESSWEEK (Oct. 15, 2013), http://www.businessweek.com/articles/2013-10-15/why-the-medical-device-tax-came-to-rule-the-debt-ceiling-talks (explaining how the repeal of a tax on medical devices was one of the conditions for ending the government standoff).

129. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2596 (recognizing the constitutionality of taxes levied on items such as cigarettes, marijuana, and sawed-off shotguns to encourage healthier behavior).

130. *See* Leonard J. Nelson, III, *Rationing Health Care in Britain and the United States*, 7 J. HEALTH & BIOMEDICAL L. 175, 189–90 (2011) (discussing budgetary limitations set on the National Health Service by the parliamentary system, which is accountable to British voters).

131. Bruce C. Vladeck, *The Political Economy of Medicare*, HEALTH AFF., Jan./Feb. 1999, at 22, 23, 26–27.

132. *Compare* TRIPP UMBACH, ASS'N OF AM. MED. COLLS., THE ECONOMIC IMPACT OF AAMC-MEMBER MEDICAL SCHOOLS AND TEACHING HOSPITALS 1 (2012), *available at*

The ACA did little to fill this gap. An astonishing omission is any common descriptor attached to coverage under the Act—comparable to "Medicare" or the names that states have used to build support for their Medicaid programs—that might have instilled at least a limited sense of "in-this-togetherness."[133] In other writing, I have suggested "Americare."[134] The ACA's expansion of private coverage has since acquired a name, but a divisive rather than a unifying one: "Obamacare." It is doubtful that solidarity will emerge around reducing wasteful health care spending or improving collective health if the ACA's program of universal coverage has bred so much sectarianism.

IV. CONCLUSION: GETTING TO HEALTH CARE AND HEALTH

If the United States cannot stop wasting $1 trillion each year on ineffective, sometimes harmful health care, we will go broke.[135] If we cannot become a healthier nation, earning more at work and spending less on care, we will go broke. Neither problem has easy solutions, and much of the nation remains ignorant or in denial of the scope and scale of the challenges.

The well-trained and well-meaning health professionals, superbly equipped health care facilities, and advanced medical therapies we depend on for care are embedded in a system that is rife with waste and inefficiency. It is hard to refute the argument that what the U.S. health care system does best is bill for services and invent new services for which it can bill. We cannot, and should not, render the system noncommercial, but we most certainly can remake the competition and innovation that health

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https://www.members.aamc.org/eweb/upload/The%20Economic%20Impact%20of%20AAMC%20Member%20Medical%20Schools%20and%20Teaching%20Hospitals_2012.pdf ("During 2011, the combined economic impact of [academic health centers] totaled more than $587 billion. AAMC members accounted for nearly 3.5 million full-time jobs, meaning that one in every 40 wage earners in the U.S. labor force works either directly or indirectly for an AAMC-member institution. This is an increase in economic impact of nearly 15 percent from 2009."), *with* Katherine Baicker & Amitabh Chandra, *The Health Care Jobs Fallacy*, 366 NEW ENG. J. MED. 2433, 2433 (2012) ("It is tempting to think that rising health care employment is a boon, but if the same outcomes can be achieved with lower employment and fewer resources, that leaves extra money to devote to other important public and private priorities such as education, infrastructure, food, shelter, and retirement savings.").

133. William M. Sage, *Solidarity: Unfashionable, but Still American*, *in* CONNECTING AMERICAN VALUES WITH AMERICAN HEALTH CARE REFORM 10, 10–12 (Thomas H. Murray & Mary Crowley eds., 2009).

134. William M. Sage, *Why the Affordable Care Act Needs a Better Name: 'Americare,'* 29 HEALTH AFF. 1496, 1496–97 (2010).

135. PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INST., THE PRICE OF EXCESS: IDENTIFYING WASTE IN HEALTHCARE SPENDING 5–6 (2008), *available at* https://www.pwc.com/cz/en/verejna-sprava-zdravotnictvi/prices-of-excess-healthcare-spending.pdf.

care markets generate. Done well, health care will become quicker, cheaper, and more reliable, the same standards we apply to products and services throughout the economy.

Getting there will require changing what we pay for and how we pay, letting information circulate as we would in other areas of commerce, and reducing regulatory and professional barriers that constrain both imagination and performance. Prices, now both high and arbitrary, must be anchored in economic reality in order to induce productive efficiency. Equally important is to get the product right. The units and bundles of health care that we purchase should do us measurable and intuitive good, rather than represent meaningless quanta set by professional habit and unthinkingly packaged into insurance policies.

Improving health is equally important. Medical care is a relatively small determinant of health, but a very expensive one. With the recent upswing in chronic disease burden, clinical medicine has regained an awareness of population health that had eluded it in the decades since antibiotics and vaccination reduced public vulnerability to infectious disease.[136] This is a favorable development, but one that must be accompanied by explicit attention to the social determinants of health that are not within the control or authority of the medical profession. Building a virtuous cycle between educational gains and health improvement should be a priority. Although state governments struggle with the competing budgetary demands of health and education, it has been well documented that healthy children learn more effectively, and that better educated people are healthier later in life.[137]

The caricatured liberal looks primarily to collective policies and processes to improve health, while the caricatured conservative relies mainly on individuals taking personal responsibility. This is a false dichotomy. Solid empirical evidence suggests that both contributions are essential: the best-designed community will not improve health if people lack self-discipline, and the most self-reliant person will fail to stay healthy if everything in the community pulls in the other direction.[138] It is

136. *See* Bodenheimer, Chen & Bennett, *supra* note 28, at 64, 68; Derek Yach et al., *The Global Burden of Chronic Diseases*, 291 JAMA 2616, 2620 (2004).

137. SUSAN H. LANDRY, EFFECTIVE EARLY CHILDHOOD PROGRAMS 21, 28, 30 (2005), *available at* http://www.childrenslearninginstitute.org/library/publications/documents/Effective-Early_Childhood-Programs.pdf.

138. Kelly D. Brownell et al., *Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue*, 29 HEALTH AFF. 379, 382–83 (2010); Boyd A. Swinburn et al., *The Global Obesity Pandemic: Shaped by Global Drivers and Local Environments*, 378 LANCET 804, 809–10 (2011).

also critical to recognize that health can be maintained and improved though private, entrepreneurial activity as well as through government fiat and funding, as the recent expansion of mobile health apps demonstrates.[139] This "upstream" health sector—services delivered to people who are living their daily lives rather than people who have been plucked from those lives and labeled "patients"—can be both innovative and lucrative, but it will not develop as long as we continue to pour unlimited funds into the "downstream" sector of services delivered in traditional acute care settings.

The skills required to move us in the right direction are familiar ones: communication, negotiation, and the determination to do things differently. The ACA lays out a constructive path, but we will not travel very far along it until we stop arguing about insurance reform and put the coverage expansion behind us.

139. William H. Frist, *Connected Health and the Rise of the Patient-Consumer*, 33 HEALTH AFF. 191, 192 (2014); Y. Tony Yang & Ross D. Silverman, *Mobile Health Applications: The Patchwork of Legal and Liability Issues Suggests Strategies to Improve Oversight*, 33 HEALTH AFF. 222, 223 (2014).