HEALTH CARE REFORM: WILL IT SUCCEED?

David Pratt *

TABLE OF CONTENTS

* David Pratt is a Professor of Law at Albany Law School. Thanks to the editors of the Journal for their hard work and for improving this article. The article is dedicated, with deep appreciation, to 4 outstanding healers: Doris Harville, Shantye Harville, Mary Ellen Drislane, M.D., and Anthony Ferraioli, M.D.

I. INTRODUCTION

Most experts agree that the American health care system is in bad shape. The U.S. spends seventeen percent of its gross domestic product (GDP) on health, about twice the average for other rich countries, yet fifty million non-elderly Americans are uninsured, and another sixteen million are under-insured.[1] In a 2010 survey, six in ten Americans rated the health care system as fair (thirty-one percent), or poor (twenty-seven percent).[2] The percentage of individuals rating the system as poor has almost doubled since 1998 (when it was fifteen percent).[3]

President Obama signed the Patient Protection and Affordable Care Act (PPACA)[4] on March 23, 2010, and the Health Care and

[1] *See* Paul Krugman, *A Healthy New Year,* N.Y. TIMES, (Jan. 1, 2007), http://select.nytimes.com/2007/01/01/opinion/01krugman.html ("In 2005, almost 47 million Americans—including more than 8 million children—were uninsured, and many more had inadequate insurance."). Moreover, the United States has "the highest infant mortality and close to the lowest life expectancy of any wealthy nation." *Id.*; U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009*, (Sept. 2010), 1, 22–24, *available at* http://www.census.gov/prod/2010pubs/p60-238.pdf [hereinafter CENSUS BUREAU REPORT 2009]; *see also* C. Schoen, M.M. Doty, S.R. Collins & A.L. Holmgren, *Insured But Not Protected: How Many Adults Are Underinsured?*, HEALTH AFF. (June 14, 2005), *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.pdf (suggesting that underinsured Americans are almost as likely as the uninsured to not receive needed medical care). The problem is not new: "American medicine is in trouble. Its costs are staggering. Its record of performance—on access, effectiveness, and efficiency—is mixed. And its future worries millions of Americans." THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 107 (Yale Univ. Press 1994).

[2] Ruth Helman, Mathew Greenwald & Assocs. & Paul Fronstin, *2010 Health Confidence Survey: Health Care Reform Does Not Increase Confidence in the Health Care System*, EMP. BENEFITS RES. INST. NOTES, Sept. 2010, at 2.

[3] *Id.* at 3*; see also* Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 538 (2006) ("[T]he quality of the health care Americans receive is no better, and in some respects worse, than that provided in many other countries that spend far less on health care and yet provide it for all of their citizens.").

[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Stephanie Condon, *Healthcare Bill Signed by Obama*, CBS NEWS (March 23, 2010, 2:45 PM), http://www.cbsnews.com/8301-503544_162-

Education Reconciliation Act (HCERA)[5] on March 30, 2010 (PPACA and HCERA are referred to collectively in this Article as the "Act").

The Act is both very complex and very controversial. The federal agencies have already issued voluminous guidance,[6] with far more to come. Current challenges to the Act have taken two main forms: a challenge to the constitutionality of the Act's individual mandate (see Section IV.B.1[b] below) and an attempt to repeal the entire Act (see Section XII below) which, given Democratic control of the House and the Presidency, is more symbolic than real. However, Republicans will probably try, through the appropriations process, to stifle implementation of the Act.[7] Also, many of the most important provisions are not effective until 2014 or later, and so may be repealed or amended if the Republicans take control of the Senate and the White House in the 2012 elections.

This Article will discuss the background of attempts to reform the health care system, and the major problems addressed by the Act: costs and cost increases; the uninsured and the under-insured; consumer protections; waste; and the quality of care.

President Obama said on May 14, 2010:

> As all Americans know, our health care system is broken. It's unsustainable for families, for businesses. It is unsustainable for the federal and state governments . . . . The fact of the matter is that the most significant driver by far of our long-term debt and our long-term deficits is ever-escalating health care costs.[8]

Interestingly, as discussed below, many experts conclude that, by focusing on expanded coverage rather than adopting strict cost controls, the Act will probably not curb future cost increases as much as is needed.

20000981-503544.html.

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

[6] U.S. DEP'T OF HEALTH & HUM. SERVS., *Preventative Regulations*, http://www.healthcare.gov/center/regulations/prevention/regs.html (last visited May 17, 2011) (noting the various agencies and interim regulations they will be implementing under the new law); *see infra* text accompanying notes 372, 430.

[7] *See, e.g.*, Steve Teske, *Senate Dems Cite Rx Coverage Gap Closure in Urging Boehner to Nix Plans to Repeal Law*, 38 BNA PENSION & BENEFITS REP. 53, 53 (2011) ("Republicans have said that if they fail to repeal the law, they will turn to other legislative strategies to disrupt it, such as attempting to cut funding for its implementation.").

[8] John K. Iglehart, *Congressional Action on Health Care Reform—An Update*, 360 NEW ENG. J. MED. 2593, 2593 (2009).

II. SOME HISTORY

A. Past Reform Efforts

There is nothing new about a widespread desire for fundamental reform of the health care system and a perception that, finally, the time is nigh: "In the Progressive era, during the New Deal, under President Truman, and during the early 1970s, advocates thought universal health insurance was imminent and were bitterly disappointed.[9] "Now, as then, entrenched interests have tried to block national health insurance by skillfully manipulating our deepest fears to protect what they regard as their interests."[10]

In his 1944 state of the Union address, President Franklin D. Roosevelt "called for a 'second Bill of Rights,' including the 'right to adequate medical care and the opportunity to achieve and enjoy good health.'"[11]

In a 1970 survey, three people out of four "agreed that the U.S. health care system was in crisis."[12] In a 1990 poll, ninety percent of those surveyed expressed the belief "that the U.S. health care system required fundamental change or a complete rebuilding."[13]

B. Obstacles to Reform

Why is reform so difficult? According to Theodore Marmor:

Each failure has its own peculiar history, but one essential fact remains: While commentators have persistently criticized the country's medical care arrangements, U.S. politics has defeated scores of universal health plans from the Murray-Wagner-Dingell schemes of the 1940s to the multiple proposals of the early 1970s, all the way to the wide range of legislative initiatives of the early

[9] MARMOR, *supra* note 1, at 6.

[10] *Id.*

[11] Eric A. Friedman, JD & Eli Y. Adashi, MD, MS, *The Right to Health as the Unheralded Narrative of Health Care Reform*, JAMA, Dec. 15, 2010, 2639, 2640 (quoting FDR Presidential Library and Museum, *State of the Union Message to Congress*, www.fdrlibrary.marist.edu/archives/address_text.html (last visited May 17, 2011)).

[12] LAURENE A. GRAIG, HEALTH OF NATIONS: AN INTERNATIONAL PERSPECTIVE ON U.S. HEALTH CARE REFORM 9 (3d ed. 1999) (citing PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 381 (Basic Books 1982)). Graig comments that "[t]hough the U.S. health care system has undergone profound changes over the past three decades, the one constant throughout this period has been a sense, real or perceived, of a crisis in the American health care system." *Id.*

[13] *Id.* at 20.

Clinton presidency. . . . Mobilizing enough voter enthusiasm to produce a counterforce to the reform barriers—ideological hostility, institutional design, and group interests—has been enormously difficult for all reformers who have tried.[14]

In 2005, Victor Fuchs and Ezekiel Emanuel cited the following obstacles to comprehensive reform: satisfaction with the status quo; single-issue constituencies that each want different changes in the system; the U.S. system of government, with its checks and balances and divided responsibilities, that are inherently resistant to radical change of any kind, economic, social, or political; the fact that "prospective losers are likely to be much more involved and effective in blocking change than prospective winners will be in promoting it;" and differences of opinion among those who favor comprehensive reform but differ over the changes they would like to see enacted.[15]

It is dangerous to underestimate the power and influence of those who, even after passage of the Act, are attacking the actual implementation of reforms that threaten them:

> The reason the system has been so resistant to change is that lots of powerful interests do very nicely with things just the way they are . . . . American doctors make a lot more money than doctors elsewhere—roughly twice as much . . . . False While higher volume is the story behind higher physician costs in the United States, the culprit for spending on hospitals and drugs is higher prices.[16]

---

[14] Theodore R. Marmor, *U.S. Health Reform Failures: The Elusive Quest for Explanations*, HEALTH AFFAIRS, 872, 872–73 (2006), *available at* http://content.healthaffairs.org/cgi/content/full/25/3/872 (reviewing PHILIP J. FUNIGIELLO, CHRONIC POLITICS: HEALTH CARE SECURITY FROM FDR TO GEORGE W. BUSH (Univ. of Kansas Press 2005)).

[15] Victor R. Fuchs & Ezekiel J. Emanuel, *Health Care Reform: Why? What? When?*, 24 HEALTH AFFAIRS 1399, 1411 (2005); *see also id.* at 1411 ("There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order") (quoting N. MACHIAVELLI, THE PRINCE AND THE DISCOURSES, 21 (M. Lerner ed. New York: Modern Library, 1940)).

[16] Steven Pearlstein, *Adding Up the Reasons for Expensive Health Care*, WASH. POST, Feb. 14, 2007, at D01. Another author stated:

> It is our shared belief that a single-payer plan is unlikely to work well if managed within and according to existing government structures. What is needed is a strongly independent agency or government corporation set—at a state or federal level—exclusively to manage the program, and well insulated from political pressures.

MARMOR, *supra* note 1, at 138. The author continued, "only a single-payer plan means the virtual abolition of an entire industry as we know it. Politicians who

> Also, the health insurance industry is very profitable: While millions remain uninsured or underinsured, the industry's profits swell. Last year, the top six health insurance companies had combined profits of more than $10 billion."[17] "What's amazing is that they netted so much after spending prodigious amounts on marketing and administration."[18] "In 2006 Wellpoint alone burned up nearly $9 billion in such costs-nearly one quarter of what it paid out in actual benefits."[19] "By contrast, in Canada's government-run single-payer system, administration accounts for only about 3[%] of total costs.[20]

C. The Clinton Plan and its Aftermath

"The most recent failure was the Clinton . . . proposal . . . which crashed spectacularly despite wide initial support"[21] and which has haunted all subsequent reform efforts. The Clinton plan proposed meaningful cost control, threatening the incomes of many stakeholders, and triggered fierce opposition:[22]

Since the Clinton plan's demise, U.S. politicians have largely avoided proposing or talking about serious cost control. After 1994, reform efforts at both the federal level (such as the State Children's Health Insurance Program) and state level (such as in Massachusetts) have concentrated on expanding insurance coverage, not restraining costs. The lesson evidently learned from the Clinton experience was that it is extraordinarily risky to take on the medical industry.[23]

According to Sherry Glied: "the Clinton plan was fundamentally flawed."[24] "Put simply, markets work only through prices, but global budgets regulate prices and limit the

---

are reluctant to take on established interests in Washington . . . and back home . . . are terrified by the anger that would result from putting health insurers out of business." *Id.* at 161.

[17] Phil Mattera, *Private Health Insurance Is Not the Answer*, ALTERNET (Feb. 23, 2007), http://www.alternet.org/story/48371.

[18] Mattera, *supra* note 17.

[19] *Id.*

[20] *Id.*

[21] David Pratt, *The Past, Present and Future of Health Care Reform*: *Can it Happen?,* 40 J. MARSHALL L. REV. 767, 771 (2007).

[22] Theodore Marmor et al., *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality*, 150 ANNALS INTERNAL MED. 485, 486 (2009), *available at* http://www.mass.gov/Ihqcc/docs/meetings/Marmor_article.pdf [hereinafter *Obama Administration*].

[23] *Obama Administration*, *supra* note 22, at 486.

[24] SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 210 (Harvard Univ. Press, 1997).

quantity of services that will be available."[25] "When health care changes as a result of the inevitable development of new and valued medical technology, the global budget becomes incompatible with managed competition."[26]

III. THE REALLY BIG PROBLEMS: ACCESS, COVERAGE AND COST

A. Access and Coverage

The U.S. Census report released in September, 2010, found that the number of uninsured Americans rose to 50.7 million in 2009 from 46.3 million in 2008.[27] "The percentage of people covered by employment-based health insurance decreased to 55.8 percent from 58.5 percent in 2008."[28] That is the lowest figure since 1987, the first year that comparable data were collected.[29] In 2001, 62.6 percent had employer-sponsored coverage.[30]

More than three-quarters of the uninsured were in working families: 61 percent were from families with one or more full-time workers and 16 percent were from families with part-time workers.[31]

The vast majority of uninsured Americans are working individuals and children of working individuals who earn less than 200 percent of the federal poverty level:[32] they make too much to qualify for Medicaid, but too little to afford employer-offered or individual coverage.[33] The likelihood of being covered by health insurance rises with income.[34]

---

[25] *Id.*

[26] *Id.*

[27] U.S. Census, *supra* note 1 at 22.

[28] *Id.*

[29] *Id.* at 22, 24.

[30] *See* U.S. CENSUS BUREAU, P60-231, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 (2006), *available at* http://www.census.gov/prod/2006pubs/p60-231.pdf; *see also* Pratt, *supra* note 21, at 785–86.

[31] KAISER FAMILY FOUND., THE UNINSURED: A PRIMER KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 5 (Dec. 2010), *available at* http://www.kff.org/uninsured/upload/7451-06.pdf.

[32] U.S. DEP'T OF HEALTH & HUMAN SERVS., OVERVIEW OF THE UNINSURED IN THE UNITED STATES: AN ANALYSIS OF THE 2005 CURRENT POPULATION SURVEY 2, 8 (2005), *available at* http://aspe.hhs.gov/health/reports/05/uninsured-cps/ib.pdf.

[33] *Id.* at 1, 3.

[34] CENSUS BUREAU REPORT 2009, *supra* note 1, Table 8; *see also* Sara R. Collins, *Health Savings Accounts: Why They Won't Cure What Ails U.S. Health Care,* Testimony Before House Committee on Ways & Means,

Minorities were much more likely to be uninsured than whites.[35] Uninsured adults were more than twice as likely to report being in fair or poor health than those with private insurance.[36] Almost half of all uninsured non-elderly adults had a chronic condition.[37]

In addition to the uninsured, another sixteen million people are "underinsured" as a result of high out-of-pocket costs relative to income.[38]

> Those with preexisting conditions like diabetes or asthma face particularly serious obstacles since insurers vary premium rates by health status and regularly deny coverage to those they regard as expensive risks . . . . Most of the nation's seven million uninsured children are eligible for the Children's Health Insurance Program or Medicaid, but are not enrolled in them.[39]

However, a 2007 poll found that "Americans remain divided,

COMMONWEALTH FUND 13 (June 28, 2006), (transcript *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Testimony/2006/Jun/Health%20Savings%20Accounts%20%20Why%20They%20Wont%20Cure%20What%20Ails%20U%20S%20%20Health%20Care/Collins_WaysandMeans_Testimony__6%2028%2006%20pdf.pdf). Ms. Collins stated:

> Lack of insurance coverage continues to be highest among families with incomes under $20,000, with more than half (53%) uninsured for at least part of 2005. But uninsured rates are climbing rapidly among adults in moderate-income families—those with incomes between $20,000 and $40,000 (under 200% of poverty for a family of four)—rising from 28% in 2001 to 41% in 2005. Young adults ages 19 to 29, meanwhile, are the fastest growing age group among the uninsured, a reflection of two factors: their loss of dependent coverage on their 19th birthday, or more importantly in terms of sheer numbers, their reclassification as adults at 19 by Medicaid and the State Children's Health Insurance Program (SCHIP). Nearly 70% of uninsured young adults are in families with incomes under 200% of poverty.

Id.

[35] FAMILIES USA, AMERICANS AT RISK: ONE IN THREE UNINSURED 4 (Mar. 2009), *available at* http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf.

[36] *The Decade Preceding Medicare Coverage,* CENTER ON AN AGING SOC'Y, Sept. 2003, at 2, *available at* http://ihcrp.georgetown.edu/agingsociety/pdfs/insurance.pdf.

[37] KAISER FAMILY FOUND., THE UNINSURED: A PRIMER KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 6 (Oct. 2007), *available at* http://www.kff.org/uninsured/upload/7451-03.pdf.

[38] Cathy Schoen et al., *Insured But Not Protected: How Many Adults Are Underinsured?*, 24 HEALTH AFF. 289, 289 (2005), *available at* http://content.healthaffairs.org/content/early/2005/06/14/hlthaff.w5.289.citation.

[39] Jonathan Oberlander & Theodore R. Marmor, *The Health Bill Explained at Last*, N.Y. REV. OF BOOKS, Aug. 19, 2010, *available at* http://www.nybooks.com/articles/archives/2010/aug/19/health-bill-explained-last.

largely along party lines, over whether the government should require everyone to participate in a national health care plan, and over whether the government would do a better job than the private insurance industry in providing coverage."[40]

In addition, some have doubted whether we are ready for universal health care:

> The large and growing uninsured population in the United States is a direct byproduct of U.S. inability to come to agreement over whether health care is a right to which all are entitled regardless of income level or a private consumer good available only to those who can afford to purchase it or receive it as a benefit of employment . . . . The issue of universal coverage surfaces at regular intervals; the United States has started down the road to national health insurance (or at least looked at the maps and plotted a trip) numerous times over the course of the past century.[41]

---

[40] Robin Toner & Janet Elder, *Poll Shows Majority Back Health Care for All*, N.Y. TIMES, Mar. 1, 2007, http://www.nytimes.com/2007/03/01/washington/01cnd-poll.html?_r=1&pagewanted.

[41] GRAIG, *supra* note 12, at 17 (citing Uwe E. Reinhardt, *Economics*, 275 JAMA 1802, 1803 (1996); Uwe E. Reinhardt, *Wanted: A Clearly Articulated Social Ethic for American Health Care*, 278 JAMA 1446, 1446–47 (1997)). She also notes:

> The United States, unlike the other nations in this study, has a marked ambivalence about whether health care is a right to which all Americans are entitled . . . . [O]ne should not blame the delivery system— \managed care—for the failure of the U.S. society to reach the consensus that most other industrialized nations have managed to achieve. Uwe Reinhardt has referred to such a consensus as a "clearly articulated social ethic" that health care is a social good that should be made available to all. Any systemic reform process to address the plight of the uninsured is doomed without such consensus.

Id. at 184. J.P. Ruger makes a moral claim:

> This article offers an alternative moral framework for analyzing [sic] health insurance: that universal health insurance is essential for human flourishing. The central ethical aims of universal health insurance coverage are to keep people healthy, and to enhance their security by protecting them from both ill health and its economic consequences, issues not adequately considered to date. Universal health insurance coverage requires redistribution through taxation, and so individuals in societies providing this entitlement must voluntarily embrace sharing these costs. This redistribution is another ethical aim of universal health insurance unaddressed by other frameworks.

J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. MED. 53, 53 (2007). Citing the constitution of the World Health Organization, the Universal Declaration of Human Rights, and the International Covenant on Economic, Social, and Cultural Rights, two authors argue that "[t]aken together, particularly under obligations stemming from UN membership, a compelling if controversial case can be made that the right to health is not only morally but

Only about half of firms with fewer than 10 employees offer insurance.[42] About 60 percent of workers at firms with 50 or fewer employees are offered coverage.[43] That could increase to 86 percent once the Act is effective, according to a recent Rand Corporation analysis, because of (1) the 2014 requirement that individuals have health insurance and (2) greater availability of lower-cost options through an exchange.[44] The study projects that, among firms this size, 3.2 million more workers will be offered coverage, once reform is fully implemented.[45]

Surprisingly, one survey found that the percentage of firms offering health benefits in 2010 increased to 69 percent, from 60 percent in 2009:

> [L]argely because of an increase in the offer rate among firms with 3 to 9 workers. Because most workers are employed by large firms, the shift among the smallest firms did not have a major effect on either the percentage of workers offered health benefits or the percentage of workers covered at their job.
>
> The reason for the large increase in offer rate is unclear. Because of the poor economic climate in 2010, it is unlikely that many firms began offering coverage this year. A possible explanation is that non-offering firms were more likely to fail during the past year, with the attrition of non-offering firms leading to a higher offer rate among surviving firms.[46]

B. Cost and Cost Increases

Health care costs have increased at several times the rate of general inflation, and are expected to continue to outpace growth

---

also legally binding on the United States." Friedman & Adashi, *The Right to Health as the Unheralded Narrative of Health Care Reform*, 304 JAMA, 2639, 2640 (Dec. 15, 2010).

[42] Sara R. Collins et al., *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010,* THE COMMONWEALTH FUND, Sept. 2010, at 1, *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/Small%20Business/1437_Collins_realizing_hlt_reform_potential_small_business_ACA_ib.pdf.

[43] Christine Eibner, Peter Hussey & Federico Girosi, *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1395 (2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1008047.

[44] *Id.* at 1395.

[45] *Id.*

[46] Kaiser Family Found., *Family Health Premiums Rise 3 Percent to $13,770 in 2010, But Workers' Share Jumps 14% as Firms Shift Cost Burden*, HEALTH RES. & EDUC. TR., *available at* http://www.kff.org/insurance/090210nr.cfm (last visited May. 17, 2011).

in the economy. The Office of the Actuary at the Centers for Medicare & Medicaid Services reported that health care spending grew 4 percent to $2.5 trillion in 2009, the slowest rate of growth since records have been kept.[47] "Many consumers decreased their use of health care goods and services partly because they had lost employer-based private health insurance coverage, and partly because their household income had declined."[48] Spending increased 4.7 percent in 2008.[49] In 2009, enrollment in private insurance declined 3.2 percent, as many workers lost their jobs.[50] Despite the slowdown in spending growth, the share of the gross domestic product consumed by health care spending rose 1 percentage point, to 17.6 percent.[51] "[H]ouseholds' share of personal income spent on health care increased to 6.2 percent in 2009, up from 6 percent in 2008 . . . ."[52] "[H]ealth spending as a share of total federal revenue increased to 54 percent in 2009, up from 38 percent in 2008."[53]

Many employers, particularly small companies, are passing on more of the cost to employees, or eliminating coverage.[54] Numerous studies have found that rates of coverage by employer-sponsored insurance are sensitive to changes in health insurance premiums.[55]

In 2009, the average annual premiums for employer-sponsored health insurance were $4,824 for single coverage and $13,375 for family coverage.[56] On average, covered workers contributed 17%

[47] Robert Pear, *Health Spending Rose in '09, but at Low Rate*, N.Y. TIMES (Jan. 5, 2011), http://www.nytimes.com/2011/01/06/health/06health.html; *see also Historical National Health Expenditure Data,* Centers for Medicare & Medicaid Services, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage (last visited May. 17, 2011).

[48] Pear, *supra* note 47.

[49] Centers for Medicare & Medicaid Services, *supra* note 47.

[50] Pear, *supra* note 47.

[51] Centers for Medicare & Medicaid Services. ,*supra* note 47.

[52] *CMS Says Health Care Spending Grew at Slowest Rate on Record During 2009*, BNA HEALTH CARE PROF. INFO. CENTER, http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-8CTUE6 (last visited May. 17, 2011) [hereinafter BNA HEALTH CARE PROF. INFO. CENTER].

[53] BNA HEALTH CARE PROF. INFO. CENTER, *supra* note 52.

[54] LISA CLEMANS-COPE, BOWEN GARRETT & THE KAISER FAMILY FOUNDATION, CHANGES IN EMPLOYER-SPONSORED HEALTH INSURANCE SPONSORSHIP, ELIGIBILITY, AND PARTICIPATION: 2001 TO 2005 35 (Dec. 2006), *available at* http://www.kff.org/uninsured/upload/7599.pdf.

[55] CLEMANS-COPE, GARRETT & THE KAISER FAMILY FOUNDATION*, supra* note 54, at 2.

[56] KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2010 SUMMARY

of the total premium for single coverage and 27% for family coverage.[57] The average annual worker contributions for single and family coverage were $779 and $3,515, respectively.[58]

The premiums for employee-only health benefits increased 5 percent in 2010 to $5,049.[59] On average, employees paid $899 annually for single coverage, up from $779 in 2009.[60] The average total premium for family coverage increased (by only 3 percent) to $13,770 in 2010, almost as much as the annual wages of a full-time minimum wage employee in 2009.[61] However, the employees' share rose by 14 percent to nearly $4,000, an increase of $482 above what they paid in 2009.[62] The amount that the employers contribute for family coverage did not increase.[63] "Since 2005, [employees'] contributions to premiums have [risen] 47 percent, while overall premiums rose 27 percent, wages increased 18 percent, and inflation rose 12 percent."[64]

Premiums for family coverage have more than doubled since 2000.[65] Employees' contributions to their coverage have increased 159 percent since 1999.[66] In addition, employees have

OF FINDINGS 1 (2010), *available at* http://ehbs.kff.org/pdf/2010/8086.pdf. Another 2010 study found that "the average employer-sponsored family premium across all states was $13,027, ranging from $14,000 to $14,700 in the six highest cost states (Alaska, Connecticut, Massachusetts, Vermont, Wisconsin, and Wyoming) and the District of Columbia to $11,000 to $12,000 in the 11 states with the lowest average . . . costs." CATHY SCHOEN ET AL., REALIZING HEALTH REFORM'S POTENTIAL: STATE TRENDS IN PREMIUMS AND DEDUCTIBLES, 2003–2009: HOW BUILDING ON THE AFFORDABLE CARE ACT WILL HELP STEM THE TIDE OF RISING COSTS AND ERODING BENEFITS 4 (Dec. 2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Dec/1456_Schoen_state_trends_premiums_deductibles_200 32009_ib_v2.pdf.

[57] John Hollon, *Survey: Family Health Premiums up 3%, but Workers' Share Jumps 14%*, TLNT (Sept. 2, 2010, 1:54 PM), http://www.tlnt.com/2010/09/02/survey-family-health-premiums-up-3-but-workers'-share-jumps-14/.

[58] KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2010 SUMMARY OF FINDINGS 1 (2010), *available at* http://ehbs.kff.org/pdf/2010/8086.pdf.

[59] *Id.*

[60] *Id.* at 1–2.

[61] *Id.*

[62] Kaiser Family Found., *supra* note 46.

[63] *Id.*

[64] *Id.*

[65] *See* Kaiser Family Found., *Survey of Employer Health Benefits 2010*, HEALTH RES. & EDUC. TR. (Sept. 2, 2010), http://ehbs.kff.org/pdf/2010/EHBS%202010%20Chartpack.pdf.

[66] Drew Altman, *Employer Health Benefits Survey 2010: Introductory Charts,* KAISER FAMILY FOUND. (Sept. 2, 2010), http://www.thefiscaltimes.com/~/media/Fiscal-Times/Research-Center/Health-Care/Think-Tanks/2010/09/02/Employer%20Health%20benefits%20survey-Charts.ashx.

to pay deductibles and copayments. 27 percent of covered employees have annual deductibles of at least $1,000, up from 22 percent in 2009.[67] "Among small firms (3-199 workers), 46 percent face such deductibles."[68]

There has been a recent trend towards increased use by employers of high deductible health plans.[69] Proponents argue that by requiring consumers to pay more from their own funds in order to obtain health care, consumers become better informed and are less likely to over-spend.[70] However, there is another side:

> Other studies have shown that, instead of a decline in over-utilization of services, high out-of-pocket expenses lead to: delays in care, medical debt, and bankruptcy. One study found that half of those surveyed with an annual deductible of $500 had problems with medical bills and medical debt (HSAs require an annual deductible of $1000 for individuals and $2000 for families). In fact, medical bills are the leading cause of personal bankruptcies in the US.[71]

Families are spending increasingly more of their earnings on medical costs. A 2010 Commonwealth Fund report found that:

> By 2009, there were 15 states in which the average annual premium for family coverage equaled 20 percent or more of median household income for the under-65 population, compared with just three states in 2003 (Table 2). In 28 states, family premiums relative to incomes averaged 18 percent or more for middle-income, under-65 households. By 2009, average premiums, including both single and family coverage, were at or above 18 percent of median income in 26 states. And no states had premiums averaging less

---

[67] Kaiser Family Found., *supra* note 46.

[68] *Id.*; *see also* SCHOEN ET AL., *supra* note 56, at 1 ("[P]remiums for businesses and their employees increased 41 percent across from 2003 [to] 2009, while per-person deductibles jumped 77 percent in large as well as small firms. If these trends continue at the rate prior to enactment of the Affordable Care Act, the average premium for family coverage will rise 79 percent by 2020, to more than $23,000. . . . If reforms slow premium growth by 1 percentage point annually, by 2020 employers and families together will save $2,323 annually for family coverage, compared with projected trends.").

[69] See, e.g., Walecia Konrad, High-Deductible Plans Grow, but Not Everyone Should Get on Board, N.Y. TIMES, Aug. 27, 2010, http://www.nytimes.com/2010/08/28/health/28patient.html.

[70] *See generally id.* ("If workers must pay a bigger chunk of their own costs, the argument goes, they will become wiser consumers of health care.").

[71] Mila Kofman, *HSAs: A Great Tax Shelter for Wealthy, Healthy People but Little Help to the Uninsured, Underinsured, and People with Medical Needs*, 7 VIRTUAL MENTOR: ETHICS J. AM. MED. ASS'N, (2005), *available at* http://virtualmentor.ama-assn.org/2005/07/pdf/oped2-0507.pdf.

> than 14 percent of median income, down from 13 states in 2003. As illustrated in Exhibit 2, cost pressures are particularly acute in the South and the South-Central United States, where premium costs are high relative to incomes. The high ratio of premiums to income often reflects the rise in premiums, as well as median incomes that are below the national average (see Table 2 for median incomes). Notably, many states with premiums above the national average have family incomes below the national average.[72]

Higher out of pocket expenses (deductibles and co-payments) also cause patients to forego needed care: The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care.[73] "Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs . . . and it increased the risk of adverse health events . . . ."[74] In addition, a review by Rice and Matsuoka "of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population."[75] "Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, [found] that insured people with out-of-pocket costs high relative to income were nearly as likely to report not accessing needed health care because of costs as were people without any coverage at all."[76]

The pattern in the U.S. is markedly different from European practice: "[m]ost western European countries place little emphasis on cost sharing as a tool for either raising revenue or containing costs for physician and hospital services. . . . [P]atient copayments tend to be nominal and often are accompanied by a

---

[72] SCHOEN ET AL., *supra* note 56, at 5.

[73] JONATHAN GRUBER, THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 2–3, 5–9 (2006), *available at* http://www.kff.org/insurance/upload/7566.pdf.

[74] SARA R. COLLINS, HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS: WHY THEY WON'T CURE WHAT AILS U.S. HEALTH CARE 10, 31 (The Commonwealth Fund, 2006), *available at* http://www.commonwealthfund.org/usr_doc/957_Collins_SenateFinance_Testimony_09-25-06.pdf.

[75] *Id.* at 10.

[76] *Id.*

set of categorical exemptions."[77] A recent study found that "(48 percent) of the families with chronic conditions in high-deductible plans reported health care–related financial burden, compared to 21 percent of families in traditional plans."[78] "Almost twice as many lower-income families in high-deductible plans spent more than 3% of income on health care expenses as lower-income families in traditional plans (53 percent versus 29 percent)."[79]

Retirees also have significant out-of-pocket medical costs. A 2009 report found that Medicare "[b]eneficiaries spent an average of $4,394 of their own money on health care services in 2005 – about 28 percent of income."[80]

According to a 2010 report by Fidelity Investments, the cost of health care in retirement has increased by 56% since 2002.[81] A 65 year old couple retiring in 2010 would need more than $250,000 to cover medical expenses.[82] This assumes that the individuals have Medicare coverage but not employer-provided retiree health benefits.[83]

> Fidelity's $250,000 health care cost estimate is a broad average. If you are healthier than most of your peers, your estimate may be lower, or if you are not as healthy, or use more expensive services, your costs may be higher. You will likely need to adjust to your personal situation. For instance, if a husband and wife live to be 92 and 94, the estimated costs could grow to $430,000.[84]

A 2008 Congressional Research Service report cited an analysis of the Health and Retirement Survey which found that "6% of households aged 75-84 paid more than 50% of their income

---

[77] Richard B. Saltman & Josep Figueras, *Analyzing the Evidence on European Health Care Reforms*, 17 HEALTH AFF., 85, 91 (1998), *available at* http://content.healthaffairs.org/content/17/2/85.full.pdf.

[78] Alison A. Galbraith et al., *Nearly Half of Families in High-Deductible Health Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden*, 30 HEALTH AFF. 322, 322 (2011), *available at* http://content.healthaffairs.org/content/30/2/322.

[79] *Id.*

[80] AARP PUB. POLICY INST., MEDICARE BENEFICIARIES' OUT-OF-POCKET SPENDING FOR HEALTH CARE SERVICES, 20 (2009), *available at* http://assets.aarp.org/rgcenter/ppi/general/ppi-2009-annual-report-100201.pdf.

[81] *Fidelity Investments Estimates Couples Retiring In 2010 Will Need $250,000 To Pay Medical Expenses During Retirement*, FIDELITY.COM (Mar. 25, 2010), http://www.fidelity.com/inside-fidelity/employer-services/fidelity-estimates-couple-retiring-in-2010-will-need-250000-to-cover-healthcare-costs.

[82] *Id.*

[83] *Id.*

[84] *Get Ready for Higher Health Care Costs*, FIDELITY.COM (July 1, 2010), https://guidance.fidelity.com/viewpoints/putting-a-price-on-healthcare.

for out-of-pocket medical expenses."[85]

IV. THE MAJOR PROVISIONS OF THE ACT

A. Introduction

The Act amends part A of title XXVII of the Public Health Service Act (PHSA), relating to group health plans and health insurance issuers in the group and individual markets.[86] PPACA adds section 715 to the Employee Retirement Income Security Act (ERISA)[87] and section 9815 to the Internal Revenue Code (the Code),[88] to make these provisions of the PHSA applicable to group health plans, and health insurance issuers providing coverage in connection with group health plans, as if those provisions were included in ERISA and the Code.[89] The PHSA sections incorporated by this reference are sections 2701 through 2728.[90] Under section 1251 of PPACA, as modified by section 10103 of PPACA and section 2301 of HCERA,[91] certain plans or coverage existing on the date of enactment ("grandfathered plans") are subject only to certain provisions, as long as they retain grandfathered status: see Section V. below.[92]

Retiree-only plans and excepted benefits, as defined by the Health Insurance Portability and Accountability Act (HIPAA), are generally exempted from the Act.[93] These excepted benefits

[85] JANEMARIE MULVEY & PATRICK PURCELL, CONG. RESEARCH SERV., R40008, CONVERTING RETIREMENT SAVINGS INTO INCOME: ANNUITIES AND PERIODIC WITHDRAWALS 5 (2008).

[86] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 141-42 (2010) (codified at 42 U.S.C. § 18001).

[87] *Id.* § 1562(e).

[88] *Id.* § 1562(f).

[89] *Id.* § 1562(e)-(f).

[90] *See* Public Health Service Act, 42 U.S.C. §§ 2701 -2728; Patient Protection and Affordable Care Act § 1001 (codified at 42 U.S.C. § 18001).

[91] Patient Protection and Affordable Care Act § 1251, *amended by* § 10103 of Patient Protection and Affordable Care Act and § 2301 of Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 2301, 124 Stat. 1029, 1081.

[92] *See infra* Part V.

[93] *See* AMERICAN BENEFITS COUNCIL, EXEMPTIONS FOR RETIREE-ONLY PLANS MUST BE PRESERVED 1–2 (May 21, 2010), *available at* http://www.appwp.org/documents/hcr_retiree-only_analysis_052110.pdf; *see also* Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 39 (June 17, 2010) (codified at 45 C.F.R. § 147.120, also codified at 26 C.F.R. § 54.9815-2714T & 29 C.F.R. § 2590.715-2714); Health Insurance Portability and Accountability Act

include coverage for accidental death and dismemberment; disability income coverage; liability insurance; workers' compensation; coverage for on-site medical clinics; and limited-scope dental, vision, or long-term care benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of a group health plan.[94]

B. Expanded Coverage

1. The Individual Mandate

(a) Description

The most controversial feature of the Act is the individual mandate, which requires the uninsured to purchase health insurance, for themselves and their dependents, or pay a tax penalty, beginning in 2014.[95] Various groups are exempt from the mandate.[96] Beginning in 2014, "applicable individual[s]" must ensure that they and all of their dependents who are applicable individuals maintain "minimum essential coverage" for each month of the tax year.[97] Failure to maintain that coverage for any month by an individual or her dependents triggers the imposition of a penalty payable with the individual's federal income tax return covering that period.[98]

The penalty is imposed on a monthly basis, and is equal to the lesser of (1) the sum of the monthly penalty amounts determined under Code section 5000A(c)(2) or (2) the national average premium for a bronze-level health plan offered through the local exchange.[99] The penalty is assessed as the lesser of a flat dollar amount or a percentage of household income.[100] Taxpayers are liable for penalties of their dependents.[101] Spouses who file joint

Pub. L. No. 104-191 § 706, 110 Stat. 1936, 1950 (1996).

[94] For a complete list of excepted benefits, see 26 C.F.R. § 54.9831-1(c)(1)-(3) (2011).

[95] 26 U.S.C. § 5000A(a)-(b)(1).

[96] *Id.* § 5000A(d)(2), (e).

[97] *Id.* § 5000A(a).

[98] *Id.* § 5000A(b).

[99] *Id.* § 5000A(c)(1). Bronze level coverage is designed to provide actuarial benefits equal to at least 60 percent of medical costs under the plan. 42 U.S.C.A. § 18022(d)(1)(A).

[100] 26 U.S.C. § 5000A(c)(2).

[101] *Id.* § 5000A(b)(1)-(3)(A).

returns are jointly and severally liable for each other's penalty payments.[102] The flat dollar monthly amount is scheduled to increase from $95 per adult for 2014 to $325 for 2015 and $695 for 2016, after which the amount is indexed for inflation.[103] The percentage of income is scheduled to increase from 1 percent in 2014 to 2 percent in 2015, with a maximum of 2.5 percent for tax years after 2015.[104] The penalty is to be assessed and collected as an "assessable penalty" in the same manner as a tax.[105] The IRS has stated that no audits will be conducted to ensure that taxpayers remit the amount.[106] According to one commentator:

> The individual mandate tax has the ability to act as an effective deterrent to would-be players. However, without sufficient enforcement strength, it becomes itself open to being gamed. Just as thousands of individuals in Massachusetts found ways to take advantage of that system, the Congressional Research Service predicts that millions of Americans will work their way around the individual mandate. Without future legislative action, the IRS will need to be creative in its enforcement because the vitality of the IMT is essential to the survival of healthcare reform.[107]

Individuals exempt from the penalty include members of Indian tribes,[108] because of special programs available to them; individuals with a lapse of coverage for less than 3 months; noncitizens; nonresident aliens; incarcerated individuals; individuals with a religious exemption, who must be members of a recognized religious sect exempting them from self-employment taxes and who adhere to tenets of the sect;[109] and dependents.[110]

A hardship exemption is available to individuals who cannot afford coverage because their required contribution for employer-

---

[102] *See id*. § 5000A(b)(3)(B).

[103] *See id.* § 5000A(c)(3).

[104] *Id.* § 5000A(c)(2)(B).

[105] 26 U.S.C.A. § 6671(a) (West 2010).

[106] Martin Vaughan, *IRS May Withhold Tax Refunds to Enforce Health-Care Law*, WALL ST. J., Apr. 15, 2010, http://online.wsj.com/article/SB10001424052702304510004575186082454662468.html.

[107] Mellor, Daniel L., *The Individual Mandate Tax: Healthcare's Toothless Watchdog*, 130 TAX NOTES 105 (2011) (citing Ben Domenech, *Congressional Research Service Confirms: Many Americans Will Game Individual Mandate*, THE NEW LEDGER (May 6, 2010), http://newledger.com/2010/05/congressional-research-service-confirms-many-americans-will-game-individual-mandate/).

[108] 26 U.S.C.A. § 5000A(e)(3).

[109] *Id.* § 5000A(d)(2)-(4), (e)(4); INTERNAL REVENUE SERV., TAX GUIDE FOR CHURCHES AND RELIGIOUS ORGANIZATIONS: BENEFITS AND RESPONSIBILITIES UNDER THE FEDERAL TAX LAW 3, 5 (Dep't of the Treasury Internal Revenue Serv. 2009), *available at* http://www.irs.gov/pub/irs-pdf/p1828.pdf.

[110] *See* § 5000A(e)(1)(A), (2).

sponsored coverage, or the lowest cost bronze plan in the local exchange, exceeds 8 percent of their annual household income.[111] There is an exemption for taxpayers whose household income falls below the income tax filing threshold.[112] The individual mandate is expected to broaden the risk pool by bringing new and healthy customers into the insurance market.[113] This is expected to reduce health care costs.[114] Insurers can no longer discriminate in price or deny coverage based on preexisting conditions,[115] creating a major adverse selection problem.[116]

> If the individual mandate is ultimately struck down but the rest of the health-reform law is ruled legal, the result will be an unsustainable system. Americans would have been promised universal coverage and insurers would have been forced to accept everyone regardless of their state of health—but free riders could easily avoid paying into the system until they fell sick. That will either bankrupt insurers or lead to huge rises in premiums.[117]

(b) The Constitutional Challenges

The better view is that the individual mandate and the associated penalty are constitutional.[118]

---

[111] *Id.* § 5000A(e)(1)(A)-(B).

[112] *Id.* § 5000A(e)(2).

[113] *See* Amitabh Chandra, Jonathan Gruber & Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293, 293 (2011), *available at* http://www.hsph.harvard.edu/centers-institutes/population-development/files/nejmp1013067.pdf (arguing that individual mandate will reduce adverse selection, which is when a large amount of unhealthy people, rather than healthy people, purchase health insurance).

[114] Tom Curry, *Everyone Into the Risk Pool—or Else*, MSNBC.COM (Aug. 11, 2009, 11:13 AM), http://www.msnbc.msn.com/id/31782553/ns/health-health_care/.

[115] 42 U.S.C. § 300gg-3(a).

[116] Adverse selection occurs when a larger fraction of relatively unhealthy people than healthy people purchase health insurance. It is analogous to the purchase of car insurance only by high-risk drivers (or worse, only by drivers who have just had an accident) . . . . The larger subsidies in Massachusetts would be expected to have a greater effect in inducing healthy people to obtain insurance than the ACA's smaller subsidies—which suggests that mandating coverage might well play an even larger role in encouraging the healthy to participate in health insurance markets nationally than it has in Massachusetts.

Chandra, Gruber & McKnight, *supra* note 113, at 293, 295.

[117] *Terminal or Curable?,* ECONOMIST, Dec. 18, 2010, at 2.

[118] See, e.g., Calvin H. Johnson, Healthcare Penalty Need Not Be Apportioned Among the States, TAX NOTES, July 19, 2010, at 335, available at http://taxprof.typepad.com/files/tax-notes-today_-2010-tnt-1..-5.pdf; Edward Kleinbard, Constitutional Kreplach, TAX NOTES, Aug. 16, 2010, at 755,

However, it is not an easy question.

> Congress has never required anyone to buy a product from private industry. This is the first reason the question is so hard . . . . The fact that the [Supreme] Court has recently issued both narrow and expansive readings of the Commerce Clause makes it almost impossible to predict how it will view the requirements of the ACA . . . . The third and most important reason the question is so hard is that it's difficult to decide whether not having insurance coverage qualifies as an activity that affects interstate commerce . . . . Why, for example, is there no constitutional fuss over Medicare, Medicaid, or veterans' health care? These programs raise no constitutional issue because they are government benefit programs funded by taxes, and the Constitution explicitly authorizes Congress to tax and spend for the general welfare. Had the ACA expanded Medicare eligibility to everyone, or created a new government health benefit program, there would be no constitutional issue. The constitutional controversy is the direct result of the insistence by conservative legislators that any health insurance reform must preserve the private insurance industry, which necessitated the addition of the individual mandate that is now being fought in the courts by similarly conservative forces.[119]

---

available at http://lawweb.usc.edu/centers/cleo/working-papers/cleo/documents/C10_13_paper.pdf**.** For a discussion of the cases, see Mel Cousins, The Patient Protection and Affordable Care Act and Constitutional Challenges: District Court Opinions to March 2011, GLASGOW CALEDONIAN UNIV., Dec. 1, 2010, at 12, 15, 34, available at http://works.bepress.com/cgi/viewcontent.cgi?article=1015&context=mel_cousins&sei-redir=1#search=%22The+health+Care+reform+Act+and+constitutional+challenges+(round+1):+Virginia+v.+Sebelius%22; Brad Joondeph, U.S. Files Response to Petition for En Banc Review in Florida v. HHS, ACA LITIG. BLOG (Mar. 18, 2011, 8:37 AM), http://acalitigationblog.blogspot.com/2011/03/us-files-response-to-petition-for-en.html; Mark A. Hall, The Constitutionality of Mandates to Purchase Health Insurance, 37 J.L. MED. & ETHICS 40, 40, 44–45, 48 (2009); Randy E. Barnett, Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional, 5 N.Y.U.J.L. & LIBERTY 581, 597, 610, 624–25, 636 (2010), available at http://ssrn.com/abstract=1680392**;** Sara Rosenbaum & Jonathan Gruber, Buying Health Care, the Individual Mandate, and the Constitution, 363 NEW ENG. J. MED. 401, 402–03 (2010). See also KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 7 (2011) (noting that Congress has provided for healthcare services through several statutes, and that "[t]he Supreme Court has recognized that Congress's power to tax is extremely broad."), available at http://healthcarereform.procon.org/sourcefiles/CRS_Constitution_Rights_HR3590.pdf; Laurence H. Tribe, On Health Care, Justice Will Prevail, N.Y. TIMES, Feb. 8, 2011, at A27 (arguing that President Obama's Health Care Plan is Constitutional and the arguments otherwise are merely politically based).

[119] Wendy K. Mariner, George J. Annas & Leonard H. Glantz, *Can Congress Make you Buy Broccoli? And Why That's a Hard Question,* 364 NEW ENG. J.

Some argue that that the penalty imposed for failure to maintain minimum essential healthcare coverage is an unconstitutional direct tax.[120] Others have described the individual mandate tax as a "toothless watchdog."[121]

The first two decisions found the law to be constitutional.[122] In the third case, the Commonwealth of Virginia argued that the individual mandate is unconstitutional and that all of Obamacare must be struck down.[123] Judge Hudson found the mandate unconstitutional stating that it "all seem[s] to distill to the single question of whether or not Congress has the power to regulate-and tax-a citizen's decision not to participate in interstate commerce."[124] He rejected the administration's argument that the uninsured impose costs on the entire health system.[125] But he refused to strike down the entire Act or to prohibit its implementation pending appeal.[126]

With admirable restraint, health law scholar Timothy S. Jost describes Judge Roger Vinson's opinion in the most recent decision, *State of Florida v. United States Department of Health and Human Services*, as "a remarkable piece of work." [127] "This decision, concluding a case brought by twenty-six state governors or attorneys general (in addition to two private parties and a business association, the National Federation of Independent Businesses), strikes down in its entirety the Patient Protection and Affordable Care Act as unconstitutional."[128] This despite the fact that the only issues left for decision were the claims that the

MED. 201, 201–02 (2011), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1014367.

[120] *See, e.g.*, Steven J. Willis & Nakku Chung, *Constitutional Decapitation and Healthcare*, TAX NOTES, July 12, 2010, at 169-70, *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1589190; Steven J. Willis & Nakku Chung, *Oy Yes, the Healthcare Penalty Is Unconstitutional*, TAX NOTES, Nov. 8, 2010, at 727, 730, *available at* http://ssrn.com/abstract=1703575.

[121] *See, e.g.*, Daniel J. Mellor, *The Individual Mandate Tax: Healthcare's Toothless Watchdog,* TAX NOTES TODAY, January 4, 2011, at 2.

[122] Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882, 895–896 (E.D. Mich. 2010); Liberty Univ., Inc. v. Geithner, No. 6:10-cv-00015-nkm, 2010 WL 4860299, at *1 (W.D. Va. Nov. 30, 2010).

[123] Virginia. ex rel. Cuccinelli v. Sebelius, 702 F. Supp. 2d 598, 601 (E.D. Va. 2010).

[124] *Id.* at 614–15.

[125] *Id.* at 602, 609, 615.

[126] *Id.* at 608, 615.

[127] Timothy Jost, *Analyzing Judge Vinson's Opinion Invalidating the ACA,* HEALTH AFF. BLOG (Feb. 1, 2011, 3:57 PM), http://healthaffairs.org/blog/2011/02/01/analyzing-judge-vinsons-opinion-invalidating-the-aca.

[128] *Id.*

Act's Medicaid expansions unconstitutionally coerce the states and that the minimum coverage requirement exceeds the authority of Congress.[129]

In one possible scenario, "the only way to satisfy . . . voters who [were] guaranteed health insurance . . . would be for the federal government to provide coverage for everyone."[130] "That would not be unconstitutional, but it would certainly not be the outcome desired by today's conservative warriors."[131]

2. The Exchanges

(a) In General

The Act requires the establishment of two Exchanges by 2014. The **American Health Benefit Exchange (AHBE)**, which allows individuals to shop for affordable policies, and the **Small Business Health Options Program (SHOP),** which allows small businesses to shop for affordable health plans.[132] There is no public option, nor a new government run plan, but HHS is required to establish a Consumer Operated and Oriented Plan (CO-OP) which will give grants to establish non-profit health insurance companies which can offer plans on the exchange.[133] Each state must have at least one.[134]

Beginning in 2014, premium assistance subsidies will be available on a sliding scale to qualified individuals, to purchase coverage on the Exchange.[135] The sliding scale begins at 100% of federal poverty level (FPL) and increases to 400% of the FPL.[136] For example if income is 100% to 133% of FPL the individual must spend 2% on premiums and the excess of the premium cost over 2% of household income will be given as a premium assistance credit.[137] If household income is between 300% and 400% of the FPL the individual must spend 9.5% on premiums and the excess premium cost will be given as a premium

129 *See id.*
130 *Terminal or Curable?, supra* note 117.
131 *Id.*
132 42 U.S.C.A. § 18031(b) (West 2010).
133 *See id.* § 18042(a); *id.* § 18024(c).
134 *See id.* § 18042(b)(1) (stating that the Secretary "shall provide" loan assistance through the co-op program and not merely that they may provide).
135 26 U.S.C.A. § 36B(a), (b)(1)–(2)(A), (3)(A)(1) (West 2010).
136 *See id.* § 36B(3)(A)(i).
137 *See id.* § 36B(b)(1)-(3)(A)(i).

assistance credit.[138] Premium increases must be justified, and a provider can be banned from Exchanges if increases are excessive as determined by HHS.[139] In addition, at least 80-85% of premium dollars must be spent on medical care or policyholders will get a rebate.[140]

The Act allows each state to establish a health insurance exchange (an "Exchange") to facilitate the purchase of qualified health plans ("QHPs") by individuals and certain employers within the state.[141] A federally-operated Exchange will serve states that will not have an Exchange in operation by January 1, 2014.[142] The Exchanges will certify QHPs, maintain an internet website by which QHPs can be compared, rate QHPs, and enroll eligible individuals in QHPs.[143]

QHPs are plans that offer coverage meeting specified standards, including the following: The plan must cover "essential health benefits" (see Section [b], below); the plan must provide limits on cost-sharing; and the coverage must provide a bronze, silver, gold, or platinum level of benefits (i.e., benefits that are actuarially equivalent to 60%, 70%, 80%, or 90%, respectively, of the full actuarial value of the benefits provided under the plan).[144] Only health plan products that include the "essential health benefits package" are eligible to be offered in the new state exchanges and are, therefore, eligible for any available premium credits and subsidies.[145] Health plan products offered to large groups are also impacted by which benefits are included in the "essential health benefits" package because of the prohibition on lifetime and annual benefit limits, which does not prevent or prohibit health plans from "placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits."[146]

(b) Essential Health Benefits

The Secretary of HHS is authorized to regulate and specify

138 *See id.*
139 42 U.S.C.A. § 300gg-94(b)-(c)(1) (West 2010).
140 *See id.* § 300gg-18(b)(1)(A).
141 *Id.* § 18031(b)(1)(A), (d)(2)(A).
142 *See id.* § 18041(a)(1), (b)-(c)(1).
143 *Id.* § 18031(d)(4)(A), (C)-(D), (F).
144 *Id.* § 18022(a), (d)(1); *see infra* Part IV.B.2[b].
145 *See id.* § 18022(b)(1)-(2)(A) (stating that all "essential health benefits" must be provided for in an employer's plan); *id.* § 300gg-11(b)(1)(A).
146 *Id.* § 300gg-11(a)(2), (b); *see* discussion *infra* Parts IV.B.2(b), IV.C.1.

other criteria for QHPs.[147] HHS, DoL and IRS issued interim final rules in June, 2010.[148] The Act directed HHS to define "essential health benefit."[149] The regulations do not define the term and until the term is defined, HHS, IRS, and DoL will take into account "good faith efforts to comply with a reasonable interpretation of the term '"essential health benefits[.]"'[150] "For this purpose, a plan or issuer must apply the definition of essential health benefits consistently."[151] The Act provides generally that:

> [E]ssential health benefits . . . include[s] at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services[;] (B) Emergency services[;] (C) Hospitalization[;] (D) Maternity and newborn care[;] (E) Mental health and substance use disorder services, including behavioral health treatment[;] (F) Prescription drugs[;] (G) Rehabilitative and habilitative services and devices[;] (H) Laboratory services[;] (I) Preventive and wellness services and chronic disease management[;] [and] (J) Pediatric services, including oral and vision care.[152]

The Secretary has requested the Institute of Medicine (IOM) to undertake a study that will make recommendations on the criteria and methods for determining and periodically updating the benefits package.[153] "The IOM will not define specific service elements . . . [but] will review how insurers determine covered benefits and medical necessity . . . ."[154] In January, 2011, an independent advisory group began to consider this issue.[155]

Jonathan Gruber, a [health] economist who helped to create the state health plan in Massachusetts, told the panel that he estimated that a 10 percent rise in the cost of the essential

---

147 *See* 42 U.S.C. § 18022(b)(4); *id.* § 18024(c).

148 Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188-01 (June 28, 2010).

149 *See id.* at 37191; 42 U.S.C. § 18022(b)(1)-(2); *id.* § 18024(c).

150 Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37191 (June 28, 2010).

151 *Id.*

152 42 U.S.C. § 18022(b)(1).

153 *Determination of Essential Health Benefits,* INST. MED. NAT'L ACADEMIES (Jan. 19, 2011, 3:48 PM), http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx.

154 *Id.*

155 N.C. Aizenman, *'Basic' Gets Tricky in the Health-Care Law*, WASH. POST, Jan. 15, 2011, at A02.

benefits package would increase the cost of government subsidies by 14.5 percent, or $67 billion, while reducing the share of the insured by 4.5 percent, or 1.5 million, through 2019.[156]

"'That must be the number-one thing in your minds,' Gruber said. 'To understand the trade-off between our desire to make insurance generous and our desire to make it affordable.'"[157] The Act directs HHS "to ensure that the essential benefits package is comparable to a 'typical employer plan.'"[158] "Did Congress mean the benefits-rich plans sponsored by large companies? The skimpy offerings purchased by many mom-and-pop concerns? Something in between?"[159]

(c) Coverage Through The Exchanges

Before 2017, the Exchanges will be open only to employers with 100 or fewer employees.[160] Before 2016, a state may restrict availability of its Exchange to employers with no more than 50 employees.[161]

Only about half of firms with fewer than 10 employees currently offer insurance.[162] About 60 percent of workers at firms with 50 or fewer employees are offered coverage.[163] That could increase to 86 percent once the Act is effective, according to a recent Rand Corporation analysis, because of (1) the 2014 requirement that individuals have health insurance and (2) greater availability of lower-cost options through an exchange.[164] The study projects that, among firms this size, 3.2 million more workers will be offered coverage once reform is fully implemented.[165] Beginning in 2017, the state may open its

156 *Id.*
157 *Id.*
158 *Id.*
159 *Id.*
160 42 U.S.C.A. §§ 18032(a)(2)(A), (f)(2)(A), (f)(2)(B)(i), 18024(b)(2) (West 2011).
161 *Id.* §§ 18032(a)(2)(A), (f)(2)(A), (f)(2)(B)(i), 18024(b)(2) (3).
162 SARA R. COLLINS, KAREN DAVIS, JENNIFER L. NICHOLSON & KRISTOF STREMIKIS, THE COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: SMALL BUSINESSES AND THE AFFORDABLE CARE ACT OF 2010 1–2, 2 exhibit 1 (2010), *available at* http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Sep/Small-Businesses.aspx (follow "Issue Brief" hyperlink).
163 Christine Eibner, Peter S. Hussey & Federico Girosi, *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1395 (2010), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1008047 (follow "PDF" hyperlink).
164 *Id.*
165 *Id.*

Exchange to large employers.[166] On August 3, 2010, HHS published a request for comments from interested parties, including the employer community.[167]

"[Twenty-nine] million Americans are expected to obtain insurance through the exchanges by 2019. This pooling of the uninsured, the reform assumes, will increase the purchasing power of the group, reduce administrative costs, and thereby produce lower-priced plans than would otherwise be available to persons without employer-based coverage."[168] Commentators have warned that adverse selection is the primary threat to the insurance exchanges.[169]

Another problem is that eligibility, for Medicaid and premium subsidies for the purchase of insurance through the exchanges, is based on income and can change over time with fluctuating income and changes in family composition.

> The law specifies no minimum enrollment period, and subsidy levels will also change as income rises and falls. Using national survey data, we estimate that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will. To minimize the effect on continuity and quality of care, states and the federal government should adopt strategies to reduce the frequency of coverage transitions and to mitigate the disruptions caused by those transitions. Options include establishing a minimum guaranteed eligibility period and 'dually certifying' some plans to serve both Medicaid and exchange enrollees.[170]

---

166 42 U.S.C.A. § 18032(f)(2)(B)(i) (West 2011).

167 Planning and Establishment of State Regulated Exchanges; Request for Comments Regarding Exchange Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 45, 584 (Aug. 3, 2010) (codified at45 CFR Part 170).

168 Oberlander & Marmor, *supra* note 39. Laxmaiah Manchikanti et al., *Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade,* PAIN PHYSICIAN JOURNAL 14, E36, E40–41 (2011), http://www.painphysicianjournal.com/2011/january/2011;14;E35-E67.pdf

169 *See* Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, COMMONWEALTHFUND.ORG (July, 15, 2010), http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx (last visited May 14, 2011).

170 Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, *HEALTH AFF. 30,* No. 2, 1, (2011), http://op.bna.com/hl.nsf/id/nwel-8dqu2l/$File/Sommerstudy.pdf.

3. Medicaid

Medicaid "cover[ed] nearly 60 million people in 2005, with an average federal contribution of 57%."[171] In 2007, more than 45% of poor, non-elderly adults were uninsured; only 15% had employer coverage.[172] From 2006 to 2007, Medicaid covered only 27.7% of poor adults.[173]

The Act expands and alters the Medicaid program by extending the program to include all individuals "under age 65 with income below 133 percent of the federal poverty line," which in 2009 was $10,830 for an individual.[174] "For the first time, Medicaid will offer coverage solely on the basis of income and regardless of family–circumstance including the single adults without children who are now excluded."[175]

> The Congressional Budget Office (CBO) estimates that, as a result, about 16 million Americans will gain insurance coverage through Medicaid. The federal government would initially pay all of the costs for this expansion, which begins in 2014; after 2020 Washington would finance 90 percent of the costs, with states funding the remainder.[176]

This will require additional funding from the states (if they choose to remain part of the Medicaid program).

In the past, Medicaid and CHIP have failed to enroll many people who are eligible for coverage.[177] "Most of the nation's seven million uninsured children are eligible for the Children's Health Insurance Program or Medicaid, but are not enrolled in them."[178] Thus, a well-planned outreach program will be essential.

---

171 Sara Rosenbaum, *Medicaid and National Health Care Reform*, 361 NEW ENG. J. MED., 2009 (Nov. 19, 2009),http://www.nejm.org/doi/pdf/10.1056/NEJMp0909449 (last visited May 14, 2011).

172 *Id.* at 2010.

173 *Id.*

174 Oberlander & Marmor, *supra* note 39; MARTHA HEBERLEIN, JOCELYN GUYER & ROBIN RUDOWITZ, FINANCING NEW MEDICAID COVERAGE UNDER HEALTH REFORM: THE ROLE OF THE FEDERAL GOVERNMENT AND THE STATES 1–2 (The Henry J. Kaiser Family Found. May 2010), *available at* http://www.kff.org/healthreform/upload/8072.pdf.

175 Oberlander & Marmor, *supra* note 39.

176 *Id.*

177 *See* Amy Davidoff, Bowen Garrett & Alshadye Yemane, *Medicaid-Eligible Adults Who are Not Enrolled: Who are They and Do They Get the Care They Need?*, NEW FEDERALISM No. A-48, 6 (2001), http://www.urban.org/UploadedPDF/310378_anf_a48.pdf; Oberlander & Marmor, *supra* note 39.

178 Oberlander & Marmor, *supra* note 39.

4. Adult Children

The Act requires plans to provide coverage for adult children until age 26.[179] Previously, many group health plans offered coverage to children only up to a younger age (typically, age 24) and, after attainment of age 19, covered only children who were full-time students.[180] The regulations prohibit employers from including requirements such as being a full-time student: with respect to a dependent who has not attained age 26, a plan may not define "dependent" for eligibility purposes other than in terms of a relationship between the parent and child.[181] The change is generally effective for plan years beginning after September 22, 2010.[182] Grandfathered plans are not exempt but, for plan years beginning before January 1, 2014, a grandfathered plan may continue to exclude adult children if the child is eligible to enroll in another employer-sponsored health plan.[183]

The regulations also include a transitional rule for a child whose health coverage ended, or who was denied coverage, because coverage ended before the child attained age 26.[184] The plan must give the child (or the employee who is the child's parent) written notice of the opportunity to enroll, and at least 30 days to enroll, by the first day of the first plan year beginning after September 22, 2010.[185] Any such child who enrolls is a "special enrollee" under HIPAA, and must be offered all benefit packages available to, and cannot be required to pay more for coverage than, similarly situated individuals who did not lose coverage by reason of cessation of dependent status.[186] The U.S.

179 42 U.S.C.A. § 300gg-14 (West 2011).

180 *See* John Holahan & Genevieve Kenney, Health Insurance Coverage of Young Adults: Issues and Broader Considerations, URBAN.ORG, (June 2008), http://www.urban.org/UploadedPDF/411691_young_adult_insurance.pdf (last visited May 14, 2011); Jerry Geisel, *Health Insurers Extend Coverage to Adult Children*, BUS. INS., (May 3, 2010), http://www.businessinsurance.com/article/20100502/ISSUE01/305029976 (last visited May 14, 2011); David Schepp, *Health Insurance for Your Dependent Children? That Depends*, DAILY FINANCE.COM, (Jun. 6, 2010, 7:00AM), http://www.dailyfinance.com/story/insurance/employers-reluctant-to-add-older-dependents-sooner-rather-than-l/19502338 (last visited May 14, 2011).

181 45 C.F.R. § 147.120(b) (2010).

182 *Id.* § 147.120(h).

183 42 U.S.C.A § 18011(4)(B)(ii) (West 2011).

184 45 C.F.R. § 147.120(f)(1)(i) (2010).

185 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1004(a), 124 Stat. 119, 140 (2010); 45 C.F.R. § 147.120(f)(2)(i) (2010).

186 45 C.F.R. § 147.120(f)(4) (2010). Regulations regarding the treatment of HIPAA special enrollees are included at 26 C.F.R. § 54.9801-6(d)(1)–(2), 29

Department of Labor (DoL) has issued model language for the notice.[187] The preamble to the regulations states that,

> The Departments have been informed that many health insurance issuers have announced that they will allow continued coverage of adult children before such coverage is required by the Affordable Care Act. A plan or issuer that allows continued coverage of adult children before being required to do so by the Affordable Care Act is not required to provide the enrollment opportunity with respect to children who do not lose coverage.[188]

According to the Employee Benefit Research Institute (EBRI),

> The overall increase in employment-based coverage due to newly enrolled 19–25-year-olds in 2011 ranges from 680,000 to 2.12 million individuals, and these costs are expected to increase health insurance premiums about 0.7 percent in 2011, 1 percent in 2012, and 1 percent in 2013. . . . This study finds these estimates may understate the size of the population that might enroll in their parents' employment-based coverage. If the initial enrollment estimates are too low, the effect of the age 19–25 provision will be higher.[189]

Some employers are considering plan revisions that would charge a higher premium for each child covered under the health plan.[190] An employer survey by the Mercer consulting firm found many companies will increase the 2011 cost of dependent coverage for their workers proportionally more than they raise premiums for single coverage.[191]

In Notice 2010-38, IRS noted that,

> In certain respects, the rules of § 2714 of the PHS Act extending coverage to an adult child do not parallel the gross income exclusion rules provided by the Affordable Care Act's amendments of §§ 105(b), 401(h), 501(c)(9), and 162(l) of the Code. For example, § 2714 of the PHS Act applies to children under age 26 and is

C.F.R. § 2590.701-6(d)(1)–(2), and 45 C.F.R. § 146.117(d).

[187] U.S. DEP'T. OF LABOR, *Model Language for Notice of Opportunity to Enroll*, http://www.dol.gov/ebsa/dependentsmodelnotice.doc (last visited May. 14, 2011

[188] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27122-01, 27125 (May 13, 2010).

[189] Paul Fronstin, *Coverage of Dependent Children to Age 26 Under the Patient Protection and Affordable Care Act*, 31 EMP. BENEFIT RES. INST. 2, 2 (2010) www.ebri.org/pdf/notespdf/EBRI_Notes_08-Aug10.PPACA_PolFrm.pdf.

[190] *See* Press Release, Mercer, Even as Reform Pushes Up Benefit Cost, Employers Will Take Steps to Hold 2011 Increase to 5.9% (Sept. 8, 2010), *available at* http://www.mercer.com/press-releases/1391585.

[191] *Id.*

> effective for the first plan year beginning on or after September 23, 2010, while, as noted above, the amendments to the Code addressed in this notice apply to children who have not attained age 27 as of the end of the taxable year and are effective March 30, 2010.[192]

The Notice stated that,

> IRS and Treasury intend to amend the regulations under § 106, retroactively to March 30, 2010, to provide that coverage for an employee's child under age 27 is excluded from gross income. Thus, on and after March 30, 2010, both coverage under an employer-provided accident or health plan and amounts paid or reimbursed under such a plan for medical care expenses of an employee, an employee's spouse, an employee's dependents (as defined in § 152, determined without regard to § 152(b)(1), (b)(2) or (d)(1)(B)), or an employee's child (as defined in § 152(f)(1)) who has not attained age 27 as of the end of the employee's taxable year are excluded from the employee's gross income.[193]

5. Early Retirees

There has been a long and well-documented decline in the number of employers that offer health plan coverage to retirees.[194] For most employers, the most expensive retirees to cover are the early retirees, i.e. those who are not yet aged 65 and thus not yet eligible for Medicare.[195] To address this problem the Act establishes a temporary reinsurance program to reimburse group health plans for certain expenses of providing health benefits to retirees aged 55 to 64.[196] The program reimburses 80 percent of plan claims between $15,000 and $90,000 (adjusted for inflation) and must be used to reduce plan costs or participant out-of-pocket expenses.[197] In order to participate, the plan must apply to HHS for certification.[198] Reimbursements are not taxable to the plan sponsor.[199] The

192 I.R.S. Notice 2010-38, 2010-20 I.R.B. 682.

193 *Id.*

194 *See* Frank Mcardle, Amy Atchison & Dale Yamamoto, *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits* (2006), http://www.kff.org/medicare/upload/7587.pdf (detailing a survey, the fifth in a series of surveys, conducted between June and October of 2006 regarding the state of retiree health care benefits).

195 *See id.* at 2, 7, 15–17.

196 42 U.S.C.A. § 18002(a)(1), (a)(2)(B)(ii), (a)(2)(C) (West 2011).

197 *Id.* § 18002(c)(2)–(4).

198 *Id.* § 18002(c)(1)(A) (referring to the Secretary of HHS).

199 *See id.* § 18002(c)(5) ("Payments received . . . shall not be included in determining the gross income of an entity . . . that is maintaining or currently

HHS Office of Consumer Information and Insurance Oversight (OCIIO) began accepting applications on June 29, 2010.[200]

The program will end no later than January 1, 2014.[201] The program may end earlier as the initial appropriation ($5 billion) is likely to be exhausted before that time: a June 7, 2010, report by the Employee Benefit Research Institute projected that the program would run out of money within two years.[202]

The Act repeals the rule that allows an employer, as health plan sponsor, to disregard the value of any retiree prescription drug plan subsidy in calculating its deduction for retiree prescription drug costs, for taxable years beginning after 2012.[203]

6. Waiting Periods

Effective for plan years beginning on or after January 1, 2014, plans may not impose waiting periods in excess of 90 days.[204]

C. CONSUMER PROTECTION AND IMPROVED BENEFITS

1. Lifetime and Annual Limits

Under the Act, a plan may no longer put lifetime limits on the amount of "essential health benefits" provided by the plan.[205] Also, a plan may generally not impose an annual limit on the amount of "essential health benefits."[206] Thus, the determination of what is included in "essential health benefits" is crucially

contributing to a participating employment-based plan.").

[200] Press Release, U.S. Dep't of Health & Human Servs., Applications for Early Retiree Reinsurance Program Now Being Accepted (June 29, 2010) [hereinafter Health & Human Services], *available at* http://www.hhs.gov/news/press/2010pres/06/20100629a.html. Additional application assistance is made available by the U.S. Department of Health and Human Services. U.S. DEP'T. OF HEALTH & HUMAN SERVS., *Ensuring the Affordable Care Act Serves the American People*, CMS.GOV, http://cciio.cms.gov/ (last visited May 14, 2011).

[201] Health & Human Services, *supra* note 200.

[202] *See* Fronstin, *supra* note 189, at 7 (finding that "if the subsidy were drawn down for all early retirees and their dependents, $2.5 billion of the $5 billion available would be exhausted in the first year of the program. The $5 billion would last no more than two years and would not be available in 2012 or 2013").

[203] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9012(b), 124 Stat. 119, 868 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, § 1407, 123 Stat. 1029, 1067 (2010).

[204] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2707(b), 124 Stat. 119, 161 (2010) (codified at 42 U.S.C. § 300gg-7).

[205] *Id.* § 2711 (codified at 42 U.S.C. § 300gg-11).

[206] *Id.*

important.[207]

These rules generally apply for plan years beginning after September 22, 2010, with no exception for grandfathered plans, but (1) "[r]estricted annual limits" may apply for plan years beginning before January 1, 2014, and (2) under a waiver program to be implemented by HHS, certain limited benefit group health plans may, for plan years beginning before January 1, 2014, request a waiver of the annual limit prohibition if imposing the prohibition would cause a significant decrease in access to coverage or a significant increase in premiums.[208]

The prohibitions do not (1) apply to specific treatment limits, like 'number of visits' limits,[209] (2) limit the ability of a plan sponsor to exclude all benefits for a specific disease or condition[210] (though such an exclusion may be limited by other state or federal laws) or (3) restrict the plan sponsor's ability to impose limits on *nonessential* health benefits.[211]

The Department of Health and Human Services (HHS), DoL and IRS issued interim final rules in June, 2010.[212]

Plans may gradually remove the annual limits, to minimize the cost effect.[213] Under the regulations, the annual limit on essential health benefits must be at least $750,000 for plan years beginning on or after September 23, 2010; $1.25 million for plan years beginning on or after September 23, 2011; and $2 million for plan years beginning on or after September 23, 2012, and before January 1, 2014.[214] If a grandfathered plan has a higher annual limit than that shown above, reducing the limit to the regulatory threshold would cause the plan to lose grandfathered status.[215]

---

[207] *See supra* Part IV.B.2[b].

[208] 45 C.F.R. § 147.126(d) (2010).

[209] *See id.* § 147.126(a).

[210] *Id.* § 147.126(b)(1).

[211] *Id.* § 147.126(b)(2).

[212] Patent Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, 75 Fed. Reg. 37,188 (June 28, 2010) (codified at 45 C.F.R. Parts 144, 146, and 147). The same interim final rules are to be codified by the Internal Revenue Service at 26 C.F.R. Parts 54 and 602, and by the Department of Labor at 29 C.F.R. Part 2590.

[213] 45 C.F.R. § 147.126(d).

[214] *Id.*

[215] Patent Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, 75 Fed. Reg. 37188-01, 37,192 (June 28, 2010) (supplementary information); Amendment to the Interim Final Rules for Group Health Plans and Health

Under the regulations, a plan must give written notice that the lifetime limit no longer applies.[216] The notice, an opportunity to enroll, and actual coverage must be provided by the first day of the first plan year beginning on or after September 23, 2010.[217] DoL has issued model language that can be used to satisfy the notice requirement.[218] Individuals generally have 30 days from the date of the notice to request enrollment.[219]

The new prohibitions generally do not apply to flexible spending accounts ("FSAs"), health savings accounts ("HSAs"), medical savings accounts ("MSAs"), and some health reimbursement accounts ("HRAs").[220] FSAs are subject to a $2,500 salary reduction contribution limitation for taxable years beginning after December 31, 2012.[221]

The Act also imposes new cost-sharing restrictions.[222] In 2014, the cost-sharing under a plan for a plan year cannot exceed the maximum out-of-pocket expenses, including the deductible, that a participant in a high-deductible plan would be required to pay.[223] Beginning in 2015, the limit will be adjusted to reflect health insurance premium increases.[224] The restrictions also limit deductibles to $2,000 for single coverage and $4,000 for family coverage.[225] Both these amounts are indexed after 2014, and the maximum may be increased by employer-funded reimbursements under a flexible spending arrangement.[226]

Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Health Care Act, 75 Fed. Reg. 70,114, 70,120-22 (Nov. 17, 2010) (codified at 26 C.F.R. 54.9815-1251T, 29 C.F.R. 2590.715-1251, & 45 C.F.R. 147.140).

216 45 C.F.R. § 147.126(e)(2).

217 *Id.* § 147.126(e)(3).

218 U.S. DEP'T. OF LABOR, *Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity*, DOL.GOV, http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc (last visited May 31, 2011).

219 45 C.F.R. § 147.126(e)(2)(i).

220 Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, 75 Fed. Reg. 37188-01, 37,190 (June 28, 2010) (supplementary information).

221 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9005(a), 124 Stat. 119, 854-55 (2010) (codified at 26 U.S.C. § 125).

222 *Id.* §§ 1201(4), 1302(c) (codified at 42 U.S.C. 300gg-6(b), 18022).

223 *Id.* § 1302(c)(1)(A) (referencing I.R.C. § 223(c)(2)(A)(ii)). For 2011, the limit is $5,950 for single coverage and $11,900 for family coverage. Rev. Proc. 2010-22, 2010-1 C.B. 747.

224 *Id.* § 1302(c)(1)(B)(i)–(ii).

225 *Id.*

226 *Id.* § 1302(c)(2)(A)(i)–(ii). Cost sharing includes "deductibles, coinsurance, copayments and similar charges". *Id.* § 1302(c)(3).

2. Preexisting Conditions

The Act (1) bans preexisting condition exclusions and premium increases based on health status, starting in 2014, and (2) prohibits the use of preexisting condition exclusions for children starting in plan or policy years that begin after September 22, 2010.[227] These provisions do not apply to grandfathered plans.[228] The interim final rules adopt, with minor modifications, the definition of preexisting condition under HIPAA.[229]

Generally, a preexisting condition is any health condition or illness that was present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.[230] The rules provide examples of what constitutes a prohibited preexisting condition exclusion and clarify that denial of coverage, based on a preexisting condition (rather than excluding from coverage benefits related to the condition), is also prohibited.[231]

The Act establishes a temporary insurance program (the PCIP program) for high-risk individuals with preexisting conditions.[232] Financing is limited to $5 billion (in addition to premiums collected from enrollees), and it will terminate (at the latest) on January 1, 2014, when the Exchanges established under the Act will be available for individuals to obtain health insurance coverage.[233] The high-risk insurance pool went into effect on June 21, 2010.[234] Eligible individuals must generally have a preexisting condition and no creditable coverage for at least six months prior to applying for pool coverage.[235]

The Act imposes sanctions on insurance issuers or employer

[227] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1255, 124 Stat. 119, 162 (codified at 42 U.S.C. §§ 300gg-3, 300gg-4).

[228] Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, 75 Fed. Reg. 37188-01, 37,190 (June 28, 2010) (supplementary information).

[229] *See id.*

[230] 45 C.F.R. § 144.103 (2010).

[231] *See id* § 147.108(a)(2).

[232] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1101, 124 Stat. 119, 141–43 (codified at 42 U.S.C.A. § 18001). HHS has issued an interim final rule. Pre-Existing Condition Insurance Plan Program, 75 Fed. Reg. 45,014, 45,029–33 (July 30, 2010) (codified at 45 C.F.R. pt. 152).

[233] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1101(g), 124 Stat. 119, 141-43 (codified at 42 U.S.C. § 18001).

[234] *See Id.* § 1101(a) (codified at 42 U.S.C. § 18001); Manchikanti et al., *supra* note 168, at E39.

[235] *Id.* § 1101(d)(2)-(3) (codified at 42 U.S.C. 18001).

plans if "high risk" employees are encouraged to disenroll in order to be eligible for the pool.[236] The PCIP will report cases in which an individual may have been discouraged from enrolling in other coverage to the appropriate authorities, e.g. DoL in the case of an ERISA plan.[237] Congress directed the Secretary to establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged individuals from remaining enrolled in prior coverage, based on the health status of those individuals.[238] The interim final rule sets forth these criteria, and requires PCIPs to establish procedures to identify and report to HHS, instances where issuers or plans are discouraging high-risk individuals from remaining enrolled in their current coverage, in instances where such individuals subsequently are eligible to enroll in the PCIP.[239]

"HHS will develop procedures to transition PCIP enrollees to the Exchange[ ] . . . [in order] to ensure . . . there are no lapses in health coverage for those individuals" enrolled in the PCIP program.[240]

The existing State high-risk pool programs will continue to operate separately.[241]

According to a report from HHS, without the provisions of the Act, as many as 129 million non-elderly Americans who have a preexisting health condition would be at risk of losing health insurance or be denied coverage altogether in 2014.[242]

3. Rescission of Coverage

A 2009 investigation and hearing by the House Committee on Energy and Commerce found that insurers (1) often abused their authority to rescind policies in order to avoid paying expensive claims and (2) frequently rescinded coverage based on trivial omissions in policyholders' applications, omissions that were

[236] *Id.* § 1101(e) (codified at 42 U.S.C. 18001).

[237] 45 C.F.R. § 152.27(b) (2010).

[238] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1101(g), 124 Stat. 119, 141–43 (codified at 42 U.S.C. § 18001).

[239] 45 C.F.R. § 152.28(b) (2010).

[240] *Id.* § 152.45.

[241] *Id.* § 152.39(a).

[242] U.S. Dep't of Health & Human Servs., *At Risk: Preexisting Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, HEALTHCARE.GOV, http://www.healthcare.gov/center/reports/.html (last visited May 14, , 2011).

often unrelated to the policyholder's illness.[243]

Jonathan Oberlander and Theodore Marmor wrote in 2009:

> The strongest case for a public plan that will protect Americans from insurance industry abuses has been made, ironically, by the industry itself. In congressional testimony on June 16, insurance industry executives from WellPoint, UnitedHealth Group, and Assurant refused to end a controversial practice known as "rescission." Under rescission, insurers retroactively cancel—often on the basis of dubious claims that policyholders haven't disclosed their complete health histories—the coverage of those who develop expensive medical conditions. That has left many people with costly medical bills for treatments that had been previously authorized by their insurance. As Lisa Girion reported in the *Los Angeles Times*, the three insurers that were included in the June 16 hearing "canceled the coverage of more than 20,000 people, allowing the companies to avoid paying more than $300 million in medical claims over a five-year period." In doing so they sought to avoid paying for the treatment of "policyholders with breast cancer, lymphoma and more than 1,000 other conditions."
>
> There is no stronger indictment of American private insurers or better example of the profit motive's corrosive influence on medicine than rescission. That insurers, even with political pressure for reform, would not forswear this practice in public hearings is stunning. It also illustrates how difficult a task it will be to transform the business practices of an industry that profits from discriminating against sick people.[244]

Under the Act, group health plans (including grandfathered plans) may not rescind coverage (i.e., terminate coverage retroactively) except in the case of an act, practice, or omission constituting fraud or an "intentional misrepresentation of material fact *as prohibited by the terms of the plan* . . . ."[245] This provision is effective for plan years beginning after September

---

[243] COMMITTEE ON ENERGY & COMMERCE STAFF, MEMORANDUM TO MEMBERS AND STAFF OF THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS: SUPPLEMENTAL INFORMATION REGARDING THE INDIVIDUAL HEALTH INSURANCE MARKET 7–13, (2009) *available at* http://democrats.energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf (finding nearly $300 million dollars in claims savings for 20,000 rescissions made by three large insurance companies over a five year period).

[244] Theodore R. Marmor & Jonathan Oberlander, *Health Reform: The Fateful Moment*, THE N.Y. REV. OF BOOKS, Vol. 56, no. 13, Aug. 13, 2009 (internal citations omitted), *available at* http://www.nybooks.com/articles/22931 (reviewing DASCHLE, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS).

[245] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2712, 124 Stat. 119, 131 (codified at 42 U.S.C. § 300gg-12) (emphasis added).

22, 2010.[246] If a rescission is warranted, the Interim Final Rules require a 30-day advance written notice to be provided to each affected participant, before coverage may be rescinded. [247] The rules do not prohibit prospective termination of coverage, or retroactive termination of coverage due to failure to pay premiums.[248]

4. Preventative Care

Health plans must provide preventive care, screening, and immunizations, without any cost-sharing.[249] HHS, DoL and IRS have published interim final regulations interpreting this requirement.[250] Generally, plans must comply by the first day of the first plan year beginning after September 22, 2010.[251] The requirement does not apply to grandfathered plans.[252]

The regulations do not contain a single list of all required services, but incorporate several lists from various sources: some are straightforward, others are not.[253]

Any future, additional recommendations must be covered as of the first plan year beginning on or after the first anniversary of when the recommendations are updated.[254] If an item or service ceases to be a recommended preventive service, a plan is no longer required to waive cost-sharing requirements with respect to that item or service.[255]

---

246 45 C.F.R. § 147.128(c) (2010).

247 *Id.* at § 147.128(a).

248 *Id.*

249 *Id.* at § 147.130(a)(ii)(iii) (2010).

250 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventative Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726–01 (July 19, 2010) (codified as amended at 45 C.F.R. 147.130).

251 45 C.F.R. § 147.130(b)(1) (2010).

252 *Id.* at § 147.140(d)–(e).

253 A current list of covered preventative services is available online. *See About the Law*: *Preventative Services Covered Under the Affordable Care Act*, HEALTHCARE.ORG, www.healthcare.gov/law/about/provisions/services/lists.html (last visited May 14, 2011); *see also* Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 41,740 *et seq*. On December 28, 2010, IRS, HHS and DoL issued a request for information on how group health plans and health insurance providers can deliver high-quality preventive care services cost-effectively under the Act. Request for Information Regarding Value-Based Insurance Design in Connection With Preventive Care Benefits, 75 Fed. Reg. 81544 (Dec. 28, 2010).

254 45 C.F.R. § 147.130(b)(1).

255 *Id.* at § 147.130(b)(2).

There is no requirement for out-of-network coverage; preventive services can be provided on an in-network basis only.[256] In the absence of guidance in the applicable government-approved recommendation, plan sponsors may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service.[257]

The regulations include rules for distinguishing between preventive and other health services during office visits, and clarify the cost-sharing requirements in that situation.[258]

5. Nursing Mothers

The Act amends § 7 of the Fair Labor Standards Act (FLSA).[259] Employers are required to provide "reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk" and to provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk."[260]

This provision took effect on March 23, 2010, and does not preempt State laws that provide greater protections.[261] The provision does not apply to exempt employees and employers with fewer than 50 employees if compliance would impose "undue hardship."[262]

6. Choice of Providers

If a plan "requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan . . . [must] permit each [such person] . . . to designate any [available] participating primary care provider . . . ."[263] Similar provisions apply to the designation of a

[256] *Id.* at § 147.130(a)(3).
[257] *Id.* at § 147.130(a)(4).
[258] *Id.* at § 147.130(a)(2).
[259] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 4207, 124 Stat. 119, 577 (2010) (codified as amended at 29 U.S.C. 207).
[260] *Id.*
[261] *See* U.S. DEP'T OF LABOR, *Fact Sheet #73: Break Time for Nursing Mothers under the FLSA,* Dol.Gov, http://www.dol.gov/whd/regs/compliance/whdfs73.pdf (last updated Dec. 2010).
[262] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 4207(3), 124 Stat. 119, 577 (codified as amended at 29 U.S.C. § 207).
[263] *Id.* § 2719A (codified at 42 U.S.C. § 300gg–19a(a)).

participating pediatrician.[264] If the plan provides coverage for obstetrical or gynecological care and requires the designation of a primary care provider, the plan "may not require authorization or referral . . . by any person . . . [for] a female participant, beneficiary, or enrollee who seeks . . . obstetrical or gynecological care [from an in-network] health care professional who specializes in obstetrics or gynecology."[265]

This provision is effective for group health plan years beginning after September 22, 2010.[266] Health plans and insurers must notify participants of their rights to: "(1) choose a primary care provider or a pediatrician [from the plan's network] . . . [and] (2) obtain obstetrical or gynecological care without prior authorization."[267] The notice must be provided (1) by the first day of the first plan year beginning after September 22, 2010 and (2) whenever the plan or issuer provides a participant with a summary plan description (or similar description of benefits).[268] The DoL has issued model language for the notice.[269]

"The three requirements relating to the choice of health care professionals apply *only* with respect to a plan . . . with a network of providers . . . . None of these requirements apply to grandfathered health plans."[270]

7. Emergency Services

If a plan "provides any benefits with respect to [ ] emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services" in a way that is consistent with the interim final regulations.[271] The plan or health insurance must cover emergency services without any prior authorization requirement, "even if the . . . services are provided

264 *Id.* § 2719A (c) (codified at 42 U.S.C. § 300gg–19a(c)(1)).

265 *Id.*

266 45 C.F.R. § 147.130(d) (2010).

267 Patent Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, 75 Fed. Reg. 37,188–01, 37194 (June 28, 2010) (supplementary information giving an overview of the Regulations). *See* 45 C.F.R. § 147.138 (2010).

268 45 C.F.R. § 147.138.

269 U.S. DEP'T OF LABOR, *Patient Protection Model Disclosure*, html:// www.dol.gov/ebsa/patientprotectionmodelnotice.doc (last visited May 14, 2011).

270 Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, 75 Fed. Reg. 37,188–01, 37193 (June 28, 2010) (emphasis added) (supplementary information giving an overview of the Regulations).

271 45 C.F.R. § 147.138(b)(1).

out-of-network . . . ."[272] For a plan with a network of emergency services providers, the plan may not "impos[e] any administrative requirement or limitation on [benefits for out-of-network services] that is more restrictive than the requirements or limitations that apply to . . . in-network [services]."[273] For a plan with a network, the regulations also provide rules for cost-sharing requirements.[274] The interim final rules do permit out-of-network providers to bill participants for the balance of the out-of-network provider rate over the amount the plan pays, if the plan pays at least a minimum amount.[275]

These requirements are effective for group health plan years beginning after September 22, 2010, but do not apply to grandfathered plans.[276]

8. Eligibility and Coverage

Effective for plan years beginning on or after January 1, 2014, plans may not base eligibility on health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or any other health status-related factor determined appropriate by the Secretary of HHS.[277] Also, plans must provide coverage to individuals participating in approved clinical trials.[278]

9. Wellness Programs

The Act codifies prior regulations allowing plans to encourage, and provide financial incentives for, participation in wellness plans.[279] Effective for plan years beginning on or after January 1, 2014, plans can generally provide wellness incentives of up to 30% of the cost of coverage.[280] The federal agencies have authority to increase this percentage to 50% of the cost of

[272] *Id.* § 147.138(b)(2)(i).
[273] *Id.* § 147.138(b)(2)(iii).
[274] *Id* § 147.138(b)(3).
[275] *Id.*
[276] *Id.* §§ 147.138(c), 147.140(c).
[277] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2705, 124 Stat. 119, 156–57 (codified at 42 U.S.C. § 300gg-4).
[278] *Id.* § 2709 (codified at 300gg-8).
[279] *See Id.* § 2705(j) (codified at 300gg-4).
[280] *Id.*

coverage.[281]

10. Claims and Appeals

The Act requires covered individuals to have access to an effective internal and external appeals process.[282] This is generally effective for plan years beginning after September 22, 2010.[283] The new regulations supplement the existing DoL regulations governing claims and appeals procedures for ERISA plans.[284] DoL is also considering further updates to its regulations and expects to issue future regulations that will propose additional, more comprehensive updates to the standards for internal plan claims and appeals processes.[285]

11. MEDICARE

The Act includes provisions that are designed to improve Medicare benefits, reduce the rate at which Medicare spending increases, improve the quality of care, and provide additional tax revenue to fund the program.[286]

Prescription drug coverage under Part D of Medicare took effect on January 1, 2006.[287] In order to control costs, the design of the program includes the notorious coverage gap, or doughnut hole: for 2010, once an enrollee had bought $ 2,830 of covered drugs, there was no further payment by Medicare until drug expenses exceeded $ 6,440.[288] Beginning January 1, 2011, enrollees' share of drug costs in the doughnut hole is reduced

[281] *Id.*

[282] *Id.* § 2719(a)(1)(A)–(B) (codified at § 300gg-19).

[283] Interim Final Rules for Group Health Insurance Relating to Internal Claims and Appeals and External Review Process Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330–01, 43, 3337 (July 23, 2010) (supplementary information).

[284] *See id.* at 43332.

[285] *Id.*

[286] PATRICIA A. DAVIS ET AL., CONG. RESEARCH SERV., R41196, MEDICARE PROVISIONS IN PPACA (P.L. 111-148) 1, 5 (2010), *available at* http://assets.opencrs.com/rpts/11-148_20100421.pdf.

[287] 42 U.S.C. § 1395w-101(a)(2) (2010).

[288] *Id.* at § 1395w-102(b); NAT'L CONFERENCE OF STATE LEGIS., *State Pharmaceutical Assistance Programs*, NCSL.ORG, http://www.ncsl.org/default.aspx?tabid=14334 (last updated Aug., 2010) (explaining the calculation of the coverage gap). Under prior law, the dollar amounts are adjusted for inflation. *See* Alicia H. Munnell and Dan Muldoon, *The Impact of Inflation on Social Security Benefits*, CENTER FOR RETIREMENT RESEARCH AT BOSTON COLLEGE, NUM. 8-15 (2008), http://crr.bc.edu/images/stories/ib_8-15.pdf.

gradually over 10 years, until 2020.[289] In 2011, those who fall into the coverage gap, which begins when total drug costs reach $2,840, will receive a fifty percent discount on brand name drugs and a seven percent discount on generics and compounded medications.[290] The out-of-pocket amount includes the full cost, not the discounted cost, of the drug.[291]

The Act also provides better preventive care, including an annual wellness visit.[292]

The Act establishes an Independent Medicare Advisory Board, to reduce the per capita rate of growth in Medicare spending and to make recommendations to Congress for maintaining or enhancing beneficiaries' access to health care.[293] The members of the Board will be appointed by the President, generally for a 6 year term, and appointment of the chair requires Senate approval.[294]

Professor Richard Kaplan concludes that, "despite the many changes the legislation makes to the American health care system, the legislation will not likely have a substantial positive effect on older Americans."[295]

The newly created Independent Medicare Advisory Board, for

---

289 42 U.S.C. § 1395w-102(b)(2)(C)(ii).

290 *See* 42 U.S.C. §§ 1395w-102(b)(2)(C), 1395w-102(b)(2)(D) (2011) (setting the 2011 generic-gap coinsurance percentage at ninety-three percent and setting the applicable drug coinsurance payment for beneficiaries within the coverage gap as the difference between the applicable gap percentage and the discount percentage); 42 U.S.C. § 1395w-114a(g)(4)(A) (2011) (defining the term "discounted price" as half of the negotiated price of an applicable drug); U.S. Dep't of Health & Human Servs., *Announcement of Calendar Year 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, CMS.GOV, http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2011.pdf (setting the initial coverage limit for 2011 at $2,840 and discussing both the manufacturer discount program and reduced cost sharing for generic drugs); KAISER FAMILY FOUNDATION, *Explaining Health Care Reform: Key Changes to the Medicare Part D Drug Benefit Coverage*, exhibit 2, 3 at 3 (2010), http://www.kff.org/healthreform/upload/8059.pdf.

291 *See* 42 U.S.C. § 1395w-102(b)(4)(C)(i) (2011) (including the annual deductible, cost-sharing, and costs resulting from the initial coverage limit as incurred costs).

292 Oberlander & Marmor, *supra* note 39.

293 42 U.S.C. § 1395kkk.

294 *Id.* at § 1395kkk(g); James C. Capretta, *The Independent Payment Advisory Board and Health Care Price Controls,* KAISER HEALTH NEWS (May 6, 2010), http://www.kaiserhealthnews.org/Columns/2010/May/050610Capretta.aspx.

295 Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans,* 18 ELDER L. J. 213, 213 (2011).

> example, is charged with reducing the per capita growth rate of Medicare's expenditures. When implemented, this Board will make substantive recommendations toward this ever-elusive goal. At the same time, the new statute prohibits the Board from making proposals "*to ration health care*, raise revenues or Medicare beneficiary premiums, . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria." One is compelled to ask in this context, "What's left?"[296]

12. Medical Loss Ratio Rules

The Act requires health plans in the individual and small group market to spend at least eighty percent of premium revenue on medical claim costs, and activities that improve health care quality; and health plans in the large group market, to spend at least eighty-five percent of premium revenue on the same, or provide premium refunds.[297] On December 1, 2010, HHS issued an interim final rule.[298]

V. GRANDFATHERED PLANS

A. In General

Certain group health plans and health insurance coverage existing on March 23, 2010 (the date of enactment of PPACA) ("grandfathered plans") are exempt from immediate compliance with certain provisions of the Act.[299]

B. Provisions Not Applicable to Grandfathered Plans

All PHSA sections cited below are incorporated into ERISA through ERISA § 715[300] and into the Internal Revenue Code

---

[296] *Id.* at 244–45 (emphasis added) (citations omitted).

[297] 42 U.S.C. § 300gg–18.

[298] Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74,864–01 (Dec. 1, 2010) (codified as amended at 45 C.F.R. § 158).

[299] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251(a), 124 Stat. 119, 161 (2010) (codified at 42 U.S.C. § 18011); *see Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, HEALTHCARE.GOV (June 14, 2010), www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html.

[300] *See* Tim Jost, *How Does the Health Reform Legislation Affect Self-Insured Plans?*, O'NEILL INST. BLOG (MAR. 31, 2010, 5:24 PM), http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans/.

through IRC § 9815.[301] Except where otherwise indicated, each provision is effective for group health plan years beginning on or after January 1, 2014.

PHSA § 2701 Fair health insurance premiums (premium rates with respect to a particular plan or coverage may only vary based on certain categories: age, tobacco use, geographic rating area, or whether the coverage is individual or family).

PHSA § 2702 Guaranteed availability of coverage ("each health insurance issuer that offers health insurance coverage must accept every employer and individual in the state that applies for such coverage").

PHSA § 2703 Guaranteed renewability of coverage (a health insurance issuer "must renew or continue in force [health insurance coverage] at the option of the plan sponsor," subject only to specified exceptions and restrictions).

PHSA § 2705 Nondiscrimination based on health status (group health plans and . . . health insurance issuers offering health insurance coverage are prohibited from discriminating against an individual with regard to eligibility or coverage based on a health status factor).

PHSA § 2706 Nondiscrimination based on health care provider (group health plans and insurers are prohibited from discriminating with respect to plan participation or coverage against any health care provider acting within the scope of that provider's license or certification under applicable state law).

PHSA § 2707 Comprehensive health coverage (health insurance issuers offering coverage in the individual or small group market must ensure that such coverage includes "essential health benefits").[302]

PHSA § 2709 Participation in clinical trials (group health plans providing coverage to a qualified individual may not deny the individual participation in an approved clinical trial).

PHSA § 2713 Coverage of preventive health services (group health plans and insurers must provide certain preventive services without imposing any cost sharing with respect to such services).[303]

PHSA § 2714 Before 2014, coverage of a dependent until age 26 if the dependent has coverage available through another

[301] I.R.C. § 9815(a)(1)-(2) (2010).

[302] *See supra* Part IV.B.2[b] (discussing essential health benefits).

[303] *See supra* Part IV.C.4 (examining preventative health care, including the effective date of such requirements).

employer.[304]

PHSA § 2715A Government reports about claims payment policies, enrollment data, and other claim information (a health plan seeking status as a "qualified health plan" must make disclosure to the insurance Exchange and the public).

PHSA § 2716 Nondiscrimination rules for insured plans (insured group health plans must satisfy the nondiscrimination rules of Code Section 105(h)(2)).[305]

PHSA § 2717 Quality of care reporting (group health plans and health insurance issuers must submit an annual report to the Secretary of HHS addressing benefits and provider reimbursement structures that may affect the quality of care).

PHSA § 2719 Claims appeal procedures (imposing additional requirements for the process of appealing a denied benefit claim).[306]

PHSA § 2719A Patient protections (including the right to designate a primary care provider, rights with respect to emergency room services and no preauthorization for obstetrical or gynecological care).[307]

C. Provisions Applicable to Grandfathered Plans

These provisions are generally effective for the first plan year beginning after September 22, 2010, unless otherwise indicated.[308]

PHSA § 2704 Prohibition on preexisting condition exclusions for individuals under 19 years of age; this is effective January 1, 2014 for individuals 19 years of age and older.[309]

---

304 *See supra* Part IV.B.4 (discussing coverage for adult children).

305 *See infra* Part VII.B (exploring nondiscrimination rules).

306 *See supra* Part IV.C.10 (acknowledging the appeals process set forth by the Act).

307 See *supra* Parts IV.C.6, IV.C.7 (providing further details, including the effective date).

308 Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Health Care Act, 75 Fed. Reg. 70114, 70,120-22 (Nov. 17, 2010) (codified at 45 C.F.R. § 147.140), amending prior regulation at 75 Fed. Reg. 34538.

309 *See supra* Part IV.C.2 (detailing the prohibition on preexisting conditions); *see* Patient Protection and Affordable Care Act, Pub. L. 111-148, § 10103(e)(2) 124 Stat. 119, 895 (codified at 42 U.S.C. § 300gg) ("the provisions of section 2704 of the PHSA (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.").

PHSA § 2708 Prohibition on excessive waiting periods: effective for plan years beginning on or after January 1, 2014, group health plans and insurers are prohibited from applying a waiting period that exceeds 90 days.

PHSA § 2711 Prohibition on lifetime and annual limits for "essential health benefits"; restricted annual limits are allowed before 2014.[310]

PHSA § 2712 Prohibition on rescissions (group health plans and insurers are prohibited from rescinding coverage unless the individual has engaged in fraud or made an intentional misrepresentation).[311]

PHSA § 2714 Requirement to cover adult children up to age 26 if the plan covers dependents (applicable to grandfathered plans for plan years beginning after September 22, 2010, unless the adult child is eligible to enroll in another employer-sponsored health; for plan years beginning on or after January 1, 2014, all plans, including grandfathered plans, are required to offer coverage to adult children up to age 26, regardless of the availability of other coverage).[312]

PHSA § 2715 Summary of benefits and coverage explanation (a four-page "summary of benefits and coverage" must be provided to applicants and enrollees before enrollment or re-enrollment, beginning March 23, 2012); also, all plans must give participants at least 60 days advance notice of any proposed benefit changes.[313]

PHSA § 2718 Reporting and rebates (health insurance issuers offering coverage in the group or individual market are required to submit reports to HHS for each plan year relating to plan costs; they may also be required to provide rebates to policyholders under certain circumstances).[314]

In addition to these provisions, certain other provisions apply to both grandfathered and non-grandfathered plans:

The early retiree reinsurance program, which became effective March 23, 2010.[315]

---

[310] *See supra* Part IV.C.1 (examining prohibition on lifetime and annual limits).

[311] *See supra* Part IV.C.3 (examining prohibition on recessions).

[312] *See supra* Part IV.B.4 (discussing coverage for adult children).

[313] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2715 124 Stat. 119, 132 (codified at 42 U.S.C. § 300gg-14).

[314] *Id.* § 2718 (codified at 42 U.S.C. § 300gg-18)

[315] *Id.* at § 1102(a)(1) (codified at 42 U.S.C. § 18002); *supra* Part IV.B.5 (discussing early retirees).

The prohibition on flexible spending account or health reimbursement account reimbursement for drug expenses unless prescribed or insulin, effective January 1, 2011.[316]

The employer requirement to report the value of health coverage on Form W-2, effective for the 2011 tax year.[317]

The annual $2,500 limitation on employee contributions to a flexible spending account, effective January 1, 2013.[318]

D. Loss of Grandfathered Status

A plan "or group health insurance coverage does not cease to be grandfathered . . . merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan . . . has continuously covered" at least one person (not necessarily the same person) since March 23, 2010. The determination is made separately with respect to each benefit package available under a plan.[319]

Under the regulations issued in June 2010, the following changes *will* generally result in loss of grandfathered status:

entering into a new policy, contract or certificate;

elimination of benefits;

an increase in a participant's percentage of cost-sharing (e.g., coinsurance), measured from March 23, 2010;

an increase in fixed-amount cost-sharing other than a copayment (e.g., a deductible) by more than the rate of medical inflation plus 15%;

an increase in a fixed-amount copayment, if the total increase, from March 23, 2010, exceeds the greater of (i) $5 increased by medical inflation; or (ii) the rate of medical inflation plus 15%;

any decrease in the employer's contribution rate by more than 5%; or

the adoption of an annual limit; the adoption of an annual limit that is lower than the lifetime limit in effect on March 23, 2010; or a decrease in the annual limit in effect on March 23, 2010.[320]

The following changes, without more, will *not* cause a plan to

316 *Id.* at § 9003(f) (codified at I.R.C. § 106).

317 *Id.* at 9002(a)-(b) (codified at I.R.C. § 6051); *See infra* Part VIII.D. (providing further discussion of this issue).

318 *Id.* at 9005(a)-(b) (codified at I.R.C. § 125).

319 Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Health Care Act, 75 Fed. Reg. 70,114, 70,120-22 (Nov. 17, 2010) (codified at 45 C.F.R. § 147.140).

320 45 C.F.R. § 147.140 (2010).

lose grandfathered status: addition of new participants or dependents, subject to an anti-abuse rule; renewal of a previous policy, certificate, or contract of insurance; changes to premiums; a decrease in the employee contribution rate; changes required to comply with federal or state law; changes to comply voluntarily with the Act; or changing a third party administrator.[321]

Comments on the interim final rule said that more flexibility in cost-sharing arrangements should be allowed for grandfathered plans.[322] They also requested that "changes in insurance providers, changes to self-insured status, and changes in employee coinsurance be permitted in certain circumstances."[323] In November, 2010, the regulation was amended to provide that a benefit option under a group health plan will *not* lose its grandfathered status if the plan sponsor enters into a new insurance policy, provided that there are no other changes that would cause a loss of grandfathered status (e.g., a reduction in benefits).[324] This amendment applies to changes in coverage that are effective on or after November 15, 2010.[325] The new rule "does not apply retroactively to such changes . . . that were effective before this date."[326] "For this purpose, the date the new coverage becomes effective is the operative date, not the date a contract for a new policy, certificate, or contract of insurance is entered into."[327]

To maintain grandfathered status, the plan must maintain records and make records available upon request.[328] The plan must also include a statement, in any materials describing benefits to participants or beneficiaries (such as an SPD), that the plan is a grandfathered plan under the Act (model language is included in the regulations); and "provide contact information

[321] *Id.*; Interim Final Rules for Group Health Insurance Relating to Internal Claims and Appeals and External Review Process Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34544 (Jul. 23, 2010) (preamble).

[322] Sara Hansard & Diane Freda, *Commenters on 'Grandfather' Rule Call for Flexibility in Cost Sharing, Plans*, 37 PENS. & BENEFITS REP. (BNA) 1862, 1862 (2010).

[323] *Id.*

[324] 26 C.F.R. § 54.9815-1251T (2010).

[325] *Id.*

[326] Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Health Care Act, 75 Fed. Reg. 70,114, 70,120-22 (Nov. 17, 2010) (codified at 26 C.F.R. 54.9815-1251T, 29 C.F.R. 2590.715-1251, & 45 C.F.R. 147).

[327] *Id.*

[328] 26 C.F.R. § 54.9815-1251T(a)(3)(i)(A)-(B).

for questions and complaints."[329]

The regulations provide transitional relief for some changes made or effective after March 23, 2010.[330] The agencies "will [also] take into account good-faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes . . . that only modestly exceed" the requirements described in the regulations.[331]

The Preamble to the June, 2010 regulations provides a mid-range estimate that 51% of all group health plans will lose their grandfathered status by 2013.[332] A survey by Hewitt Associates found that "[n]inety percent of companies . . . anticipat[ed] losing grandfathered status by 2014, with the majority expecting to do so in the next two years:" "most companies expect to lose grandfather status because of health plan design changes (72 percent) and/or changes to company subsidy levels (39 percent)."[333]

According to survey results released in August 2010, by the National Business Group on Health, "[a] majority of large employers . . . were moving ahead with modest changes in their health care benefits for 2011" that might cause them to lose grandfathered status, primarily because they did not see much value in maintaining grandfathered status.[334]

E. Collectively Bargained Plans

The Preamble to the regulations issued in June 2010, clarifies that there is no special delayed effective date for collectively bargained plans (insured or self-insured) in effect on March 23, 2010.[335] Grandfathered collectively bargained plans must comply

[329] *Id.* § 54.9815-1251T(a)(2)(i)–(ii).

[330] *Id.* § 54.9815-1251T(g)(2)(A)–(C).

[331] Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Health Care Act, 75 Fed. Reg. 70,114, 70,120–22 (Nov. 17, 2010) (codified at 26 C.F.R. 54.9815-1251T, 29 C.F.R. 2590.715-1251, & 45 C.F.R. 147.140).

[332] 75 Fed. Reg. **§** 34538, 34552 (June 14, 2010).

[333] HEWITT, *For Most Large Employers, Flexibility to Change Health Care Programs Outweighs Benefits Gained Under Grandfather Provisions*, HEWITT.ASSOCIATES.COM (Aug. 10, 2010), http://www2.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=881.

[334] Florence Olsen, *Employers Will Change 2011 Health Benefits, Grandfathered Status Not Critical, NBGH Says*, 37 PENS. & BENEFITS REP. (BNA) 1864, 1864 (2010).

[335] 75 Fed. Reg. 34538, 34542 (2010).

with the new rules at the same time as other grandfathered plans.[336] However, an *insured* plan maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, remains grandfathered at least until the date on which the last such collective bargaining agreement terminates.[337]

VI. EMPLOYERS AND EMPLOYER PLANS

A. Employers

There is no *direct* employer mandate: employers are encouraged to provide healthcare coverage to employees through a mix of incentives and penalties.

Effective January 1, 2014, an employer with at least 50 employees which (1) does not offer a specified minimum level of health coverage, and (2) has at least one employee receiving a federal subsidy (premium assistance or other cost sharing) to purchase health care coverage on an Exchange, must pay a non-deductible monthly tax of $166.67 (one-twelfth of $2,000) per full-time employee (including employees who receive no government subsidy, but ignoring the first 30 full-time employees).[338]

A separate non-deductible penalty is imposed if the employer offers coverage but the coverage does not satisfy specified levels of affordability: (i) the employee's cost for the coverage must not exceed 9.5% of the employee's household income, and (ii) the actuarial value of the benefits covered under the plan must equal or exceed 60% of the cost of the covered services.[339] Employers who offer coverage that does not satisfy these requirements must pay a monthly tax of $250 (one twelfth of $3,000) for each full-time employee who receives a federal subsidy, with a cap equal to $166.67 per full-time employee (including employees who receive no government subsidy), ignoring the first 30 full-time employees.[340] The payment will only be applied to those employees who cannot afford to participate in the employer's plan.[341]

The penalties are indexed for inflation. The 50 employee threshold generally requires an employer to have had at least 50

336 *Id.*
337 *Id.*
338 I.R.C. § 4980H(a),(c) (2010).
339 I.R.C. § 36B(b)(3) (2010); I.R.C. § 5000A (2010); 29 U.S.C. § 218b (2010).
340 I.R.C. § 4980H(b) (2010).
341 I.R.C. § 5000A(e)(1) (2010).

full-time employees on more than 120 days during the preceding calendar year.[342] For purposes of the rules, a full-time employee is an employee who works at least 30 hours per week.[343] Part-time employees count on a full-time equivalent basis.[344] Affiliated employers are aggregated.[345]

Beginning in 2014, penalties are also imposed on certain individuals who do not obtain health insurance.[346]

A business with more than 200 employees must automatically enroll new full-time employees in its health plan, if any.[347] Employees can opt out.[348] Employers must notify employees of the plan's auto-enrollment provisions and their right to opt out of coverage.[349]

Effective March 1, 2013, when an employer hires a new employee, the employer must notify the employee about the health care exchange and the availability of premium assistance for insurance purchased through the exchange if the employer provides less than 60% of the cost of coverage under its plan.[350] The notice must also state that, if the employee chooses coverage through the exchange, the employee will lose the benefit of the employer's contribution toward the cost of coverage (other than those instances where the employee is eligible to receive a voucher).

Beginning in 2014, employers must provide free choice vouchers for their portion of the premium payment, to any employee who does not participate in the employer's plan.[351] The employee's portion of the premium must exceed 8%, but not exceed 9.8%, of annual household income.[352] The employee's household income must be between 100% and 400% of the federal poverty level.[353]

The amount of the voucher is the amount that the employer would have paid under the option for which the employer pays

342 I.R.C. § 4980H(c) (2010).
343 *Id.*
344 *Id.*
345 *Id.*
346 *See supra* Part IV.B.1.
347 29 U.S.C. § 218a (2010).
348 *Id.*
349 *Id.*
350 *Id.* § 218b.
351 Patient Protection and Affordable Care Act, Pub. L. 111-148, § 10108(a)(c)(1)(C), 124 Stat. 119, 912 (codified at 42 U.S.C. § 18101).
352 *Id.* § 10108(a)(c)(1)(A)(i)(ii).
353 *Id.* § 1801(c) (1) (B).

the largest portion of the premium.[354] The employee can use the voucher to purchase coverage on the Exchange.[355] If the voucher is used by the employee, the exchange must credit the amount of the voucher to the employee's monthly premium, and the employer must pay those amounts to the exchange.[356] If the amount of the voucher exceeds the amount of the premium paid for exchange-based coverage, the excess must be paid to the employee.[357] An individual who receives a voucher cannot take a tax credit or cost sharing credit otherwise associated with the purchase of a plan on the exchange.[358] No penalty is assessed on the employer with respect to an employee who receives a voucher.[359]

B. Will Employers Stop Providing Coverage?

For many years, most Americans with health insurance have received their coverage through an employer-sponsored plan.[360] About 170 million Americans get their health coverage through a job.[361] The Act aims to preserve that structure.

According to a 2006 article,

> Health care costs at current levels override the incentives that have historically supported employer-based health insurance. Now

---

354 *Id.* § 1801(d).

355 *Id.* § 1801(d)(2).

356 *Id.*

357 Patient Protection and Affordable Care Act, Pub. L. 111-148, § 10108(d)(3), 124 Stat. 119, 912–13 (codified at 42 U.S.C. § 18101).

358 *Id.* § 1801(d)(2)–(3).

359 *Id.* § 10108(g) (providing that employers are able to deduct, as compensation, the amount of a free choice voucher paid to employees).

360 *See, e.g.,* David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82 (2006) ("More than 159 million Americans . . . had health care coverage through employer-sponsored insurance in 2004." "[E]mployer-sponsored insurance is . . . as vital . . . to the health care of Americans as the drugs, devices, and medical services that the insurance covers."); Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 405 (2004) ("[T]he vast majority of Americans under 65 who have health insurance . . . obtain it through their current jobs."); Catherine Hoffman et al., *Holes in the Health Insurance System—Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390 (2004) ("Rising health care costs and economic insecurity . . . threaten the bedrock of the health insurance system—employer-sponsored coverage.").

361 U.S. Census Bureau, *Table HIA-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1999 to 2009*, CENSUS.GOV, www.census.gov/hhes/www/hlthins/data/historical/files/hihistt1.xls (last visited May 17, 2011).

> that health costs loom so large, companies that provide generous benefits are in effect paying some of their workers much more than the going wage - or, more to the point, more than competitors pay similar workers. Inevitably, this creates pressure to reduce or eliminate health benefits. And companies that can't cut benefits enough to stay competitive such as GM - find their very existence at risk.[362]

Some comments suggest that employers will drop coverage because "the amount of the penalty is strangely low—$ 2,000 for employers that fail to offer coverage, $ 3,000 for employers that offer non-qualifying coverage,"[363] far lower than the cost of providing coverage even to the employee alone. "Even the most optimistic supporter of the PPACA would not venture that health insurance premiums will drop below $ 3,000. Therefore, basic economics would predict that employers will choose to terminate their health insurance plans and simply pay the penalty."[364]

Other comments disagree:

> The truth is that most employers will find it in their best interest to continue to offer coverage . . . . Some employers may find they can simultaneously improve total compensation and reduce their organization's total labor costs . . . . Crunch the numbers and most employers will conclude that it is financially advantageous to stay in the ESB game and continue to offer coverage. However, the economics of subsidizing it have clearly changed.[365]

Others have expressed concern that health care reform "may induce employers to redesign their health plans to encourage employees who are likely to consume a greater-than-average amount of medical services to opt out of employer-provided coverage and instead acquire coverage on the individual market."[366] They suggest that, if properly designed, an employer

---

[362] Paul Krugman & Robin Wells, *The Health Care Crisis and What to do About It*, THE N.Y. REV. OF BOOKS 38, 39, Mar. 23, 2006 (reviewing Henry J. Aaron et al., Can We Say No? (2005).

[363] HINDA CHAIKIND & CHRIS L. PETERSON, CONG. RESEARCH SERV., R41159, SUMMARY OF POTENTIAL EMPLOYER PENALTIES UNDER PPACA (P.L. 111-148) (2010).

[364] Jerry Geisel, *Employers Weigh Costs of Keeping, Dropping Health Coverage*, WORKFORCE.COM (Apr. 5, 2010), http://www.workforce.com/section/news/article/employers-weigh-costs-keeping-dropping-health-coverage.php).

[365] Steve Ferruggia, *Health Care Reform's Impact on Rewards Strategies: is it time to change the mix of compensation and benefits?*, HEALTHCARE REFORM MAGAZINE.COM (Aug. 3, 2010), http://healthcarereformmagazine.com/article/health-care-reform-s-impact-on-rewards-strategies-is-it-time-to-change-the-mix-of-compensation-and-benefits-.html.

[366] Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health*

dumping strategy can promote the interests of both employers and employees by shifting health care expenses to the general public.[367]

An Urban Institute study suggested that the size of the employer will be an important factor:

> The [new health care reform law] will have different implications for employers, depending upon their size and whether they currently offer health insurance coverage to their workers. The new law does not impose new requirements on small employers (fewer than 50 workers), but will provide new health insurance alternatives to them . . . . Slightly larger employers . . . may face some new requirements related to their workers' health insurance coverage, but will also have access to [new insurance] options . . . . [L]arger firms are unlikely to experience significant changes in the types of coverage they provide, [but] they may face higher costs associated with increased take-up of the policies [that] they offer . . . . Small employers have the most to gain under the PPACA employer provisions.[368]

In 2014, when the exchanges go into effect, "'[t]here is clearly a cohort where dropping insurance makes a ton of sense.'"[369]

The authors of a RAND corporation study estimated that there will be "a large net increase in employer-sponsored [health] insurance offers."[370]

> We predict that the number of workers offered coverage will increase from 115.1 million (84.6% of the approximately 136.0 million U.S. workers) to 128.7 million (94.6%) after the reform. This increase is not driven by penalties levied on employers with more than 50 workers. In fact, the probability of being offered coverage increases proportionately more for workers at small firms . . . . Currently, only 60.4% of workers at business with 50 or fewer

Care Reform by Dumping Sick Employees?, 97 VA. L. REV. 125, abstract (2011), http://www.virginialawreview.org/content/pdfs/97/125.pdf.

[367] *Id.* at 129–30.

[368] Linda J. Blumberg, *How Will the Patient Protection and Affordable Care Act Affect Small, Medium, and Large Businesses?*, URBAN INST. 1, 1 (2010) http://www.urban.org/uploadedpdf/412180-ppaca-businesses.pdf. *See also* BUREAU OF NAT'L AFFAIRS, BNA- 1-6-11, OUTLOOK 2011: MEDICAL LOSS RATIO, EXCHANGES, ACOS TOP ISSUES 1, 3 (2011) ("Experts do not expect large numbers of employers to drop insurance for employees in 2011, but PPACA's requirements will increase costs still further for plans that already face underlying health care cost increases.") (hereinafter OUTLOOK 2011).

[369] OUTLOOK 2011, *supra* note 368 (quoting Joshua Raskin, managing director of Barclays Capital).

[370] Christine Eibner et al., *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1394 (2010), http://www.nejm.org/doi/pdf/10.1056/NEJMp1008047.

> employees have an offer of coverage; the proportion is projected to increase to 85.9% after the reform . . . driven primarily by two factors: greater demand for coverage by workers due to individual penalties for being uninsured and the availability of new, often lower-cost insurance options (because of administrative savings, for example) for small businesses that offer coverage on the exchanges.[371]

Many employers are probably still on the fence: according to a recent survey, few workers expect employers to drop coverage after 2014, and very few employers plan to drop coverage, but employers are evenly split between having decided to continue to offer coverage and being undecided about the future of employment-based health coverage.[372]

C. The Small Business Tax Credit

The Act provides a temporary tax credit to small businesses that provide health coverage to employees.[373] The credit is refundable for tax-exempt employers. An employer is eligible if (1) it has fewer than 25 full-time equivalent employees for the year, taking into account the employer aggregation rules of Code § 414, (2) it pays average wages of less than $50,000 per full-time employee, and (3) it pays at least 50% of the premiums.[374] For tax years beginning in 2010 through 2013, the maximum credit is 35% of the employer's premium expenses, or 25% in the case of tax-exempt employers.[375] For 2014 and 2015, the tax credit increases to 50% (35% for tax-exempt employers) and is only available to businesses purchasing coverage in an Exchange.[376] The credit begins to be phased out when the number of employees exceeds 10 and average wages exceed $25,000. Also, the maximum credit will be less than the percentages shown above if the employer's cost exceeds the average premium for the small group market in the area in which the employer is offering

---

371 *Id.* at 1394–95.

372 Paul Fronstin, *Employer and Employee Reactions to Health Reform: Findings From the 2010 EBRI/MGA Consumer Engagement in Health Care Survey and the 2010 SHRM Organizations' Response to Health Care Reform Poll*, 32 EMP. BENEFIT RES. INST. 1, 4 (Jan. 2011), http://www.ebri.org/pdf/notespdf/Notes.Mar11.FinalFlow-Hlth-Accts.pdf.

373 Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1421, 124 Stat. 119, 120 (codified at I.R.C. § 45R (a) (2010)).

374 *Id.* § 1421(d)(1)(A)–(B), (3)(B)(i)–(ii), (4), (e)(1)(B) (codified at I.R.C. § 45R).

375 *Id.* § 1421(b).

376 *Id.*

coverage, as determined by HHS.[377]

IRS has issued guidance on: (1) determining whether an employer is eligible for the tax credit; (2) calculating the credit; and (3) claiming the credit and the effect on estimated tax, alternative minimum tax, and deductions.[378]

> The National Federation of Independent Business, a small business advocacy group, says that the credit will have only a limited effect because its duration is limited and its conditions are too restrictive. 'Small businesses tend to operate on a very thin profit margin,' the federation said in a statement, 'so any increase in the cost of doing business . . . presents a real challenge . . . .'"[379]

D. Self Insured Plans

Self-insured plans are currently the most common source of health care coverage for U.S. workers. In 2009, 82.1% of firms with 500 or more employees offered self-insured health plans; 25.7% of firms with 100-499 employees offered such plans; and 13.5% of firms with fewer than 100 employees offered self-insured plans.[380] Some comments suggest that health care reform will result in a decline in the number of self-insured plans, because the Act severely restricts the freedom of plan design that previously existed.[381] The Act adds new compliance burdens, and plans may want or need the help of an insurance company to ensure compliance.[382]

If insurance premiums rise significantly, employers may continue to be self-insured or switch to self-insurance if they think that they can save money by doing so. Conversely, if premiums decline significantly, some self-insured plans may move to being fully insured.

Most of the changes made by the Act under the general

---

[377] *Id.*

[378] I.R.S. Notice 2010-44, 2010-22 I.R.B. 717; I.R.S. Notice 2010-82, 2010-51 I.R.B. 1.

[379] ALLIANCE FOR HEALTH REFORM , *Implementing Health Reform: Employer and Consumer Issues,*ALLHEALTH.ORG (Dec. 1, 2010), http://www.allhealth.org/publications/Private_health_insurance/Employer_and_Consumer_Issues_with_endnotes_102.pdf.

[380] Kathryn Linehan, *Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market*, NAT'L HEALTH POL'Y FORUM 1, 3 (2010), http://www.nhpf.org/library/issue-briefs/IB840_PPACASmallGroup_12-21-10.pdf.

[381] Monahan & Schwarcz, *supra* note 366, at 138–39.

[382] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2717, 124 Stat. 119, 146, 149 (codified at 42 U.S.C. § 300gg-17).

heading "*Health Insurance Market Reforms"*[383] apply to most self-insured arrangements (e.g., the new rules relating to **waiting periods, annual and lifetime limits, rescissions, coverage of adult children and pre-existing conditions).**[384]

The Act also imposes new cost sharing restrictions that arguably apply to non-grandfathered self-insured group health plans, as well as to insured group health plans.[385]

The Act imposes procedural requirements that did not apply under prior law,[386] including: "[a]ll employer-sponsored group health plans . . . [must] give participants at least 60 days advance notice of proposed benefit changes;"[387] employer group health plans must adopt a program of auto-enrollment for eligible employees;[388] and group health plans must implement a new appeals process, including external review.[389]

The Act also subjects employer-sponsored plans to new reporting requirements, including: submitting an annual report to HHS and plan participants that addresses whether plan benefits and coverage satisfy certain standards relating to the quality of health care;[390] reporting the cost of coverage on participants' Forms W-2;[391] notifying employees about the health care exchanges and, if the employer pays less than 60% of the cost of benefits provided under the group health plan, the benefits available to employees, such as a tax credits and cost sharing reductions, if the employee purchases coverage through the exchange.[392]

> These many rules and any upcoming changes will undoubtedly alter the calculation of whether it makes economic sense for an employer to offer an insured or self-insured group health plan and, in some instances, to offer any group health plan to its employees

383 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, pt. I, 124 Stat. 119, 154.

384 *See, e.g.,* SHEARMAN & STERLING, *Self-Insured Medical Plans After Health Reform*, EXEC. COMP. & EMPLOYEE BENEFITS 2, 3–4 (2010), http://www.shearman.com/self-insured-medical-plans-after-health-reform-04-29-2010/ (click 'View full memo, "Self-Insured Medical Plans After Health Reform"').

385 *See supra* Part IV.C.1.

386 *See, e.g.*, SHEARMAN & STERLING, *supra* note 384.

387 *Id.* at 5.

388 Patient Protection Affordable Care Act, Pub. L. No. 111-148, § 1511, 124 Stat. 119, 252 (codified at 26 U.S.C. § 6055).

389 *Id.* § 2719(a)(1)(A)-(C) (codified at 42 U.S.C. § 300gg-19).

390 *Id.* §§ 2717(a)(1)–(2) (codified at 42 U.S.C. 300gg-17), 2718(a)(3) (codified at 42 U.S.C. § 300gg-18).

391 *Id.* § 9002, *amending* I.R.C. § 6051(a).

392 *Id.* § 1512(a)(1)–(3) (codified at 29 U.S.C. § 218B).

> . . . . While it is often difficult to predict outcomes when such complicated legislation is involved, we suspect that, as the process unfolds, some employers may find that the road to self-insurance is increasingly more difficult to navigate.[393]

A recent issue brief published by the National Health Policy Forum[394] suggests that, as the provisions of the Act take effect, the benefits of self-insuring health plans may make doing so more attractive to small businesses.[395] The Act includes certain exemptions for self-insured employer plans. For example, insured plans in the individual and small group market are

> not required to provide coverage with minimum essential benefits; [i]ndividual and small-group plans are required to participate in a risk-adjustment system, but self-insured plans are exempt; [s]elf-insured plans are not subject to provisions (specifically, medical loss ratio requirements and review of premium increases) . . . intended to limit insurer earnings; [and] [s]tarting in 2014, health insurers [must] pay an annual fee, . . . but self-insured plans [need not].[396]

The study suggests that:

> In 2014 and beyond, smaller employers with relatively healthy workers that have low medical costs may find it financially advantageous to pay for their own firm's risk (with a third-party administrator vendor and stop-loss coverage) than to purchase a plan through the exchange (or outside of the exchange), where, because of small-group market reforms, their workers' premiums will be a function of the broader risk pool and subject to risk adjustment. If enough small firms with healthier enrollees opt out of a state's small-group market in 2014, that state exchange could experience adverse selection.[397]

If this occurs, the cost of obtaining insurance through the exchanges will increase. The Act requires HHS, in consultation with DoL, to study fully insured and self-insured group health plan markets. The study is due by March 23, 2011.[398]

---

393 SHEARMAN & STERLING LLP, *supra* note 380, at 6.
394 Linehan, *supra* note 384.
395 *Id.* at 7–9.
396 *Id.* at 8.
397 *Id.* at 9.
398 *Id.* at 10.

VII. TAX ISSUES

A. Taxation of Employer Provided Coverage

1. In General

In 2009, the largest income tax preference was the exclusion of the value of employer-sponsored health insurance, at $ 144 billion.[399]

An individual may claim an itemized deduction for unreimbursed medical expenses of the individual and his or her spouse and dependents, including health insurance premiums, but only if and to the extent that those expenses exceed 7.5 percent of adjusted gross income ("AGI").[400] After 2012, the threshold to claim an itemized deduction for unreimbursed medical expenses is increased to 10% of AGI.[401] Anyone 65 and older can continue to deduct medical expenses in excess of 7.5% of AGI for the years 2013 through 2016.[402]

Benefits received under personally purchased health insurance policies are also excluded from income.[403] Individuals who buy their own insurance are treated less favorably than those who receive coverage under an employer-sponsored plan: first, they receive no exclusion from payroll taxes[404]; second, they receive a tax benefit only if they itemize deductions; third, they receive a tax benefit only if their unreimbursed expenses exceed 7.5% of AGI (even then, they receive no benefit on the expenses under the 7.5% threshold); and finally, the deductible medical expenses category is more narrowly defined[405] than it is for excludable reimbursements from an employer-sponsored plan[406].

---

399 Donald B. Marron, *Cutting Tax Preferences is Key to Tax Reform and Deficit Reduction*, URBAN BROOKINGS TAX POLICY CTR. 1, 8 (2011), http://www.urban.org/uploadedpdf/1001492-Marron-Cutting-Tax-Preferences.pdf (citing data from the Office of Management and Budget (2010)).

400 I.R.C. § 213(a). The threshold is ten percent (rather than 7.5%) for alternative minimum tax purposes. I.R.C. § 56(b)(1)(B). The term 'medical care' is defined in I.R.C. § 213(d)(1)(A)–(D).

401 I.R.C. § 213(a) *amended by* Pub. L. No. 111-148, § 9013(a), 124 Stat. 868 ("striking '7.5 percent' and inserting '10 percent.'").

402 *Compare* I.R.C. § 213(a), (f), *with* PPACA § 9013(a), (b).

403 I.R.C. § 104(a)(3). Unlike employer-paid insurance, the benefits are excluded even if they exceed the amount of medical care expenses incurred, but this is rarely the case. *Compare id. with* I.R.C. § 105(b).

404 *See* I.R.C. § 3121(a).

405 *See* I.R.C. § 213(a), (d)(1) (defining the term "medical care").

406 *See* I.R.C. § 106(a).

Certain individuals are eligible for a refundable income tax credit based on the cost of qualified health insurance coverage, including some employer-sponsored insurance, state-based insurance, and insurance purchased in the individual market.[407]

A health savings account ("HSA"), like an IRA, is generally exempt from income taxation.[408] Any amount paid or distributed from an HSA "which is used exclusively to pay qualified medical expenses . . . shall not includible in gross income."[409] Any such amount which is not used exclusively to pay qualified medical expenses is generally included in the gross income of the beneficiary, and is also generally subject to an additional income tax.[410] If any amount paid or distributed from a HSA is rolled over to another HSA for the same beneficiary, the amount is not currently taxable.[411] This is limited to one rollover in any one-year period, but this limitation does not apply to direct trustee-to-trustee transfers.[412] An interest in an HSA may be transferred tax-free to the beneficiary's spouse or former spouse in connection with a divorce and, after the transfer, is treated as an HSA of the spouse.[413] An HSA can be established with or without any employer involvement.[414]

As David Broder noted in 2007, these tax benefits "represents a $200 billion-a-year subsidy, with most of the benefits going to the well-to-do—a sum that could be much better spent on helping the uninsured."[415]

---

[407] I.R.C. § 35(a) (2010). *See* I.R.C. § 35(e) (defining qualified health insurance).

[408] *See* I.R.C. § 223 (a), (e); *see also* I.R.C. § 223 (d) (defining and delimiting "health savings account").

[409] I.R.C. § 223(f)(1).

[410] I.R.C. § 223(f)(2). In certain circumstances, taxation can be avoided if a mistaken distribution is timely repaid to the HSA. I.R.S. Notice 2004-50, 2004-33 I.R.B. 196.

[411] I.R.C. § 223(f)(3), (5).

[412] I.R.C. § 223(f)(5) (A)–(B). *See* I.R.S. Notice 2004-50, 2004-33 I.R.B. 196 (ruling that trustee to trustee transfers are unrestricted).

[413] I.R.C. § 223(f)(7).

[414] *See* I.R.C. § 223(c)(1)(A). *See also* 26 C.F.R. § 54.4980G-3 (2009) (illustrating that sole proprietors and partners that are self employed may have their own HSA).

[415] David S. Broder, *Health Coverage's Momentum*, WASH. POST, Feb. 4, 2007, at B07. *See also* C. Eugene Steuerle, *Defining Our Long-Term Fiscal Challenges: Testimony Before the U.S. Senate Budget Committee,* URB. INST. (Jan. 30, 2007), http://www.urban.org/url.cfm?ID=901037 ("[T]he employee exclusion for employer-provided health benefits is scheduled to grow continually faster than the economy. The additional amounts spent on this exclusion—over and above some base amount – likely lead to an increase in the number of

The Joint Committee on Taxation noted in 2006:

> The appropriateness of the present-law Federal tax treatment of health expenses has been the subject of much debate. . . . The present . . . treatment of employer-provided health coverage has been justified on the grounds that it encourages employees to prefer health coverage over taxable compensation, thereby increasing health insurance coverage and reducing the number of uninsured. Proponents . . . also argue that the employer market provides a natural pooling mechanism which can result in more affordable coverage. However, others argue that the . . . rules are inequitable because they do not provide a consistent tax benefit for health coverage and that the exclusion may lead to over utilization of health care.[416]

The exclusion for health insurance is "'a regressive entitlement, since . . . about three quarters of these dollars go to the top half of the income distribution.'"[417] At about $250 billion per year, it is the government's third largest health insurance expenditure after Medicare and Medicaid.[418] The top executive's health plan is typically more valuable than a low-paid employee's, magnifying the disparity. "The more expensive a health plan is, the more valuable the tax exclusion for it becomes."[419] According to Victor Fuchs, top Goldman Sachs executives-who are not exactly struggling to get by- receive a tax-free $40,000 per year health insurance policy.[420]

The tax rules are inequitable, because they do not provide the same level of tax benefits for everyone. Those who do not have employer-provided coverage - who are more likely to be low income employees - receive less favorable treatment than those who do, in several ways: they receive a tax benefit only if they itemize deductions, and even then only if their unreimbursed medical expenses exceed 7.5 percent of their AGI.[421] In addition,

uninsured because they add to spending on health, which, in turn, add to the cost of insurance. The higher cost insurance drives out some employers from offering insurance and drives away some consumers from buying it.").

[416] JOINT COMMITTEE ON TAXATION, JCX-27-06, PRESENT LAW AND ANALYSIS RELATING TO THE TAX TREATMENT OF HEALTH SAVINGS ACCOUNTS AND OTHER HEALTH EXPENSES 2 (2006).

[417] Iglehart, *supra* note 8, at 2594–95.

[418] *Id.* at 2594.

[419] Seth Hanlon, *Tax Expenditure of the Week: Tax-Free Health Insurance*, CENTER FOR AM. PROGRESS (Jan. 12, 2011), http://www.americanprogress.org/issues/2011/01/te_011211.html.

[420] Victor R. Fuchs, *Four Health Care Reforms for 2009*, 361 NEW. ENG. J. MED. 1720, 1721 (2009).

[421] JOINT COMMITTEE ON TAXATION, *supra* note 416, at 12. *See* I.R.C. § 213(a)

individual health insurance policies are typically more expensive and provide less comprehensive coverage than group policies.[422] Even for those lower income individuals who do receive a tax benefit (an exclusion or a deduction) their tax subsidy is less valuable than it is to those in a higher income tax bracket.[423]

2. The Act

The Act does not change the basic tax rules described above. However, for tax years beginning after 2017, the Act imposes a 40% non-deductible excise tax on a provider of high-cost (Cadillac) employer sponsored healthcare.[424] The provider is the insurer, in the case of an insured plan; the employer, in the case of contributions to a HSA or MSA; and the benefits administrator in any other case. Initially, the cost threshold is (1) $10,200 for single and $27,500 for family coverage; multiplied by (2) a health cost adjustment percentage; adjusted by (3) an employer-specific adjustment for age or gender characteristics of that employer's workforce that make coverage more expensive; and increased for (4) coverage of retirees and members of high-risk occupations.[425] After 2018, the threshold is increased for inflation.[426]

Henry Aaron comments:

> I wish that [the] tax applied to more plans and started sooner. That it does not results from the refusal of Republicans in the course of the reform debate to do anything else than vote "'no.'" The first president to embrace limits on the tax breaks for employer-financed health insurance was Ronald Reagan. Republicans have long embraced such reforms. Had they been true to their tradition and participated actively and constructively in this debate, as a previous generation of Republicans did in the debate leading up to the enactment of Medicare and Medicaid, and as Democrats did in the process leading up to the passage of the Medicare Modernization Act in 2003, there is little doubt that

(2010) (stating what can and cannot be deducted).

422 JOINT COMMITTEE ON TAXATION, *supra* note 416, at 16 n.3.

423 *See id.* at 12 n.24 (noting the refundable tax credit provides a greater tax benefit than the exclusion). "However, the credit is available to only limited classes of taxpayers. Less than one-half million taxpayers per year are estimated to be eligible for the credit." *Id*.

424 I.R.C. § 4980I(a)(i)–(ii).

425 I.R.C. § 4980I(b)(3)(C)(i)–(iv); *see also* Alistair M. Nevius, *Health Care Reform Reshapes Tax Code,* J. OF ACCT., Apr. 1, 2010 *available at* http://www.journalofaccountancy.com/Issues/2010/May/20102731 (explaining the excise tax on high-cost employer plans).

426 I.R.C § 4980I(b)(3)(C)(v); Nevius, *supra* note 425.

coverage of the tax on high-cost plans would have been broader and it would have started sooner.[427]

B. Non-Discrimination

Since 1980, self-insured health plans been subject to Code § 105(h), which prohibits discrimination in eligibility or benefits in favor of "highly compensated individuals."[428] Under § 105(h), highly compensated individuals are those who are: (a) among the five highest paid officers; (b) shareholders owning more than 10% of the employer; and (c) the highest paid 25% of employees.[429] If a self-insured plan fails to meet the nondiscrimination requirements, the highly compensated individuals are taxed on some or all of their benefits.[430]

The Act extends these nondiscrimination rules to insured health plans. IRS has issued guidance on the new requirements.[431] The statutory effective date is plan years beginning after September 23, 2010,[432] but IRS has now ruled that compliance is not required until after regulations or other guidance have been issued.[433]

A grandfathered plan is not subject to the new rules.[434]

Under a discriminatory *self-insured* plan, discrimination results in additional income taxation to the highly compensated individuals.[435] A discriminatory *insured* plan may be subject to suit under ERISA, and the plan sponsor may be liable for a penalty of $100 multiplied by the number of individuals discriminated against and the number of days the plan does not comply.[436]

Although enacted in 1978, § 105(h) has not been enforced consistently. In 1986, Congress enacted the notorious Code § 89, which attempted to apply uniform nondiscrimination rules to health and welfare plans.[437] Because of its complexity, § 89 was

---

[427] Henry J. Aaron, *'Multiple Fictions' Drive Opposition to Health Law*, KAISER HEALTH NEWS (Jan. 19, 2011), http://www.kaiserhealthnews.org/Columns/2011/January/011911aaron.aspx.

[428] I.R.C. § 105(h)(2)(A)–(B).

[429] *Id.* § 105(h)(5).

[430] *Id.* § 105(h)(1).

[431] I.R.S. Notice 2010-63, 2010-41 I.R.B. 420.

[432] *Id.*

[433] I.R.S. Notice 2011-1, 2011-2 I.R.B. 259.

[434] *Id.*

[435] *Id.*

[436] I.R.C. § 4980D(b)(1) (2011); *id*.

[437] JEFFREY D. MAMORSKY, EMPLOYEE BENEFITS LAW ERISA AND BEYOND

repealed before going into effect.[438] Time will tell whether the new provision will fare any better.

C. Medicare Taxes

In 2011, employees and employers each pay a tax equal to 1.45 percent of wages.[439] The tax is part of the funding for Medicare Part A.[440] Self-employed individuals pay 2.9 percent of their net earnings from self-employment.[441]

For taxable years beginning after 2012, there is an additional tax on individuals who receive more than a certain amount of wages during the year: $250,000 for married taxpayers filing a joint return, $200,000 for a single taxpayer, and $125,000 for a married taxpayer filing separately.[442] The tax is equal to 0.5% of the excess. The thresholds are not adjusted for inflation.[443] For a self-employed individual, no part of the additional tax is deductible.[444] Unlike the basic 1.45 percent tax, in the case of a joint return, the additional 0.5% tax is on the combined wages and earned income of both spouses.[445]

For taxable years beginning after 2012, there is also imposed on individuals a new tax equal to 3.8% of the lesser of (1) net investment income for the year or (2) the excess (if any) of (a) the modified adjusted gross income (MAGI) for the year over (b) the threshold amount.[446] A similar tax applies to estates and trusts.

---

§ 6.07 (2003), *available at* 2003 WL 23523657.

[438] *Id.*

[439] I.R.C. §§ 3101(b), 3111(b).

[440] CTR. FOR MEDICARE & MEDICAID SERVS., No. 11396, HOW IS MEDICARE FUNDED? (2009), *available at* http://www.medicare.gov/Publications/Pubs/pdf/11396.pdf (referring to "hospital insurance" as the source of funding for Medicare Part A). "Hospital Insurance" is codified in I.R.C. §§ 3101(b), 3111(b).

[441] I.R.C. § 1401(b).

[442] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9015, 124 Stat. 119, 870–72 (2010) (codified at I.R.C. §§ 1401, 3101); Health Care and Education Reconciliation Act, Pub. L. No. 111-152, § 1402, 124 Stat. 1029, 1060–63 (2010) (codified at 26 I.R.C §§ 1401, 3101).

[443] Patient Protection and Affordable Care Act § 9015 (codified at I.R.C. §§ 1401, 3101); Health Care and Education Reconciliation Act § 1402 (codified at 26 I.R.C §§ 1401, 3101).

[444] Patient Protection and Affordable Care Act § 9015 (codified at 26 I.R.C. § 164(f)).

[445] JOINT COMMITTEE ON TAXATION, JCX-18-10,TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT," 104 (2010), a*vailable at* http://www.jct.gov/publications.html?func=startdown&id=3673.

[446] I.R.C. § 1411.

The threshold amount is $250,000 for a joint return or a surviving spouse, $125,000 for a married taxpayer filing a separate return, and $200,000 in any other case.[447] The thresholds are not adjusted for inflation. Net investment income includes income from passive activities, a trade or business of trading in financial instruments or commodities, and investment of working capital, subject to an exception for certain active interests in partnerships and S corporations.[448] Net investment income does not include any distribution from a tax-favored retirement plan or any item taken into account in determining self-employment income.[449]

Higher-income beneficiaries pay additional Part B premiums. Under prior law, the income thresholds at which the higher premiums took effect were adjusted for cost-of-living increases.[450] The Act freezes the income levels at the 2010 amounts for 2011 through 2019.[451]

D. Reporting to IRS

For taxable years beginning after 2010, the value of healthcare benefits must be reported each year on employees' W-2s.[452] Members of Congress are seeking to eliminate the reporting requirement, citing the record-keeping burden on small businesses.[453]

On February 2, 2011, the Senate voted on two amendments related to the Act, as part of the Federal Aviation Administration reauthorization. The Senate voted 81-17 to repeal the new tax-filing requirement.[454] Following this vote, the Senate voted on

447 *Id.*

448 I.R.C. § 1411(c).

449 *Id.*

450 *See* Rande Spiegelman, *On Personal Finance: Healthcare Taxes*, CHARLES SCHWAB (Mar. 30, 2010), http://www.schwab.com/public/schwab/research_strategies/market_insight/financial_goals/tax/healthcare_taxes.html (noting the difference in treatment of threshold income amounts between the present "alternative minimum tax" regime and the new requirements imposed under healthcare reform).

451 Patient Protection and Affordable Care Act, 111 P.L. 148, § 3402,124 Stat. 119, 488–89 (2010) (codified at 42 U.S.C. § 1395r).

452 Patient Protection and Affordable Care Act § 9002, (codified at I.R.C. §§ 6051(a)(12)–(14)).

453 Robert Pear, *Many Push for Repeal of Tax Provision in Health Law*, N.Y. TIMES, Sept. 11, 2010, *available at* http://www.nytimes.com/2010/09/12/health/policy/12health.html.

454 Jennifer Haberkorn, *Full Repeal of Health Care Law Fails in Senate*, POLITICO (Feb. 2, 2011), http://www.politico.com/news/stories/0211/48730.html;

party lines, 51-47, to reject an amendment offered by Senate Republicans to repeal the entire Act.[455]

VIII. COSTS AND COST SAVINGS

A. Cost Control: The Role of a Public Plan

The Act does not include a public plan as an option for non-elderly Americans buying health insurance. However, in evaluating the strengths and weaknesses of the Act, it is illuminating to consider why a public plan could have helped to improve coverage and control costs.

In a letter to Senators Baucus and Kennedy on June 2, 2010, President Obama wrote that he "strongly believe[s] that Americans should have the choice of a public health insurance option operating alongside private plans."[456] Basic rationales for a public plan are

> that it would provide an alternative to for-profit private insurers who have long shunned sicker, higher-risk Americans. Even if reform legislation introduces regulations to prevent such discrimination, there is no guarantee that the insurance industry will reliably abide by them.[457]
>
> . . .
>
> A second rationale for establishing a public plan was that it could effectively control its health spending. Like Medicare, a new federal health insurance program for Americans under sixty-five has the capacity—with its purchasing power—to restrain the prices it pays to hospitals, doctors, and other medical providers. Such a public plan, which would not need to make profits, almost surely would have lower administrative costs than private plans—for example, the traditional Medicare program devotes only 2 percent of its expenditures to administration, as compared to 11 percent for private Medicare Advantage plans.[458]

Many advocates of reform would essentially have extended Medicare to all Americans. For instance, Jacob Hacker's proposed "Health Care for America" would enable every legal

---

TOM KOUTSOUMPAS ET AL., HEALTH CARE REFORM UPDATE 2 (2011), *available at* http://www.mlstrategies.com/articles/health-3-20-11.pdf.

[455] Haberkorn, *supra* note 454.

[456] Letter from President Obama to Chairmen Edward M. Kennedy and Max Baucus (June 2, 2009), *available at* http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus/.

[457] Marmor & Oberlander, *supra* note 244.

[458] *Id.*

resident of the U.S. who lacks access to Medicare or good employer coverage to buy into a new public insurance pool modeled after Medicare.[459] Employers would provide coverage as good as the new plan or contribute six percent of payroll to the Health Care for America plan.[460] "The self-employed could buy into the plan by paying the same payroll-based contribution; those without workplace ties would be able to buy into Health Care for America by paying an income-related premium."[461] The states would be given powerful incentives to enroll any remaining uninsured.[462]

Fundamental reform would have broken away from multi-insurer plans funded by employers and with high administrative costs.[463] As Robert Reich noted in 2007:

> a single payer . . . would avoid the current insanity by which private insurers spend hundreds of millions of dollars a year advertising and marketing to younger and healthier beneficiaries, and seeking to discourage older and riskier ones, or people with pre-existing medical conditions. America now has the only health-insurance system in the world designed to avoid sick people.[464]

The Act falls short in this respect: as two California advocates noted wryly, "[a] strange thing happened on the way to health-care security—the goal of universal health care morphed into the cause of mandatory health insurance purchases."[465] Ezekiel Emanuel and Victor Fuchs suggested in 2007 that there are five

---

[459] JACOB S. HACKER, HEALTH CARE FOR AMERICA: A PROPOSAL FOR GUARANTEED, AFFORDABLE HEALTHCARE FOR ALL AMERICANS BUILDING ON MEDICARE AND EMPLOYMENT-BASED INSURANCE 2 (2007), *available at* http://www.sharedprosperity.org/bp180/bp180.pdf.

[460] *Id.* at 3.

[461] *Id.*

[462] *Id.* at 4.

[463] *See, e.g.*, Paul Krugman, *The Health Care Racket*, N.Y. TIMES, Feb. 16, 2007, http://select.nytimes.com/2007/02/16/opinion/16krugman.html?pagewanted (noting that "McKinsey estimates the cost of providing full medical care to all of America's uninsured at $77 billion a year"). Mr. Krugman continues, "[e]ither eliminating the excess administrative costs of private health insurers, or paying what the rest of the world pays for drugs and medical devices, would by itself more or less pay the cost of covering all the uninsured. And that doesn't count the many other costs imposed by the fragmentation of our health care system." *Id.*

[464] Robert B. Reich, *Bush's Health Care Plan Deserves One Cheer, but One Cheer Only*, PHYSICIANS FOR A NAT'L HEALTH CARE PROGRAM (Jan. 24, 2007), http://www.pnhp.org/news/2007/january/bushs_health_care_p.php.

[465] Jamie Court & Judy Dugan, *Beware What the Medical-Industrial Complex Loves*, S.F. GATE (Feb. 22, 2007), http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/02/22/EDGRJN77ON1.DTL.

essential changes: "[g]et businesses out of health care;" "[g]uarantee every American an essential benefits package . . . modeled on what members of Congress get;" finance the universal basic package "by a dedicated tax that everyone pays, such as a value-added tax;" "[a]dminister the program through an independent National Health Board and regional boards modeled on the Federal Reserve System;" and "[e]stablish an independent Institute for Technology and Outcomes Assessment to systematically evaluate new technologies and quantify their health benefits in relation to their costs."[466]

According to Robert Reich, commenting on a 2007 proposal from President Bush:

> [t]he President's health-care proposal deserves one cheer for the following reason: [i]t potentially de-couples health care from employment.
>
> . . .
>
> The President's plan to de-couple health insurance from employment merits only one cheer, though, because it's only the first step. Two cheers for the President or any politician who comes up with a way to get health insurance to lower-income people who can't afford it on their own even with a tax deduction. It's called universal health care. Every advanced nation has it except the United States.
>
> . . .
>
> Finally, three cheers for the politician who bypasses America's inefficient private insurance market and establishes a single payer that provides all Americans with health insurance just as good as the health insurance their representatives in Congress receive free of charge. Note I said single payer, not single provider. Americans want to keep their choice of doctor and hospital.[467]

The insurance industry and its allies opposed a public option on the basis that it would create an unlevel playing field and would increase government involvement in health care.

> The insurance industry is, in fact, not interested in anything like a 'level playing field.' Buffeted by the erosion of employer-sponsored insurance, the industry now welcomes the prospect of health reform that extends private insurance to the uninsured. But insurance firms do not want to lose new or existing customers (and profits) to a public competitor . . . . The American Medical

[466] Ezekiel J. Emanuel & Victor R. Fuchs, *Beyond Health-Care Band-Aids*, WASH. POST, Feb. 7, 2007, http://www.fresh-thinking.org/publications/EzekielJEmanuel_VictorRFuchs_BeyondHealthCareBandAids_washingtonpost.com.pdf.

[467] Reich, *supra* note 464.

> Association, fearing the impact on physician incomes, also opposes . . . a strong public option . . . .[468]

According to Marmor and Oberlander:

> [t]he controversy over a strong, Medicare-like public plan in the current debate is consequential because most of the instruments for cost control under consideration in Congress are strikingly weak. None of the House and Senate bills has any system-wide limits on health spending akin to the budgets and spending targets that other nations employ to restrain health care costs. The administration and congressional Democrats have instead substituted a set of politically more appealing policies: paying hospitals and doctors on the basis of the quality of care provided, enhancing preventative medicine, promoting electronic medical records, investing in more research on the effectiveness of medical treatments, and improving the coordination of care for chronic diseases.
>
> These measures have appeal largely because they emphasize goals that no one would challenge—a healthier population and higher-quality medical care. They seem like benign devices to moderate health spending. Although the Obama administration refers to such reforms as "game changers," there is little evidence that they can effectively control costs.
>
> The irony is that, on the one hand, conservatives oppose the public plan because it will be so inexpensive it will drive out private insurance, while on the other hand, these same critics decry the inefficiency and unaffordability of government programs. For an example, see Karl Rove, "How to Stop Socialized Health Care," The Wall Street Journal, June 11, 2009."[469]

The Act does not include any system-wide controls on medical costs. Confronting enormous opposition over its proposals to expand coverage, the administration essentially deferred addressing the political problems of cost control. "But the experience of Massachusetts shows that the issue cannot be avoided for long . . . . Yet while Massachusetts officials are discussing cost control options, they have not adopted any serious spending limits to date, a reminder of how difficult the next stage of health reform remains."[470]

A recent study of Massachusetts found that its health reforms, which provide near-universal insurance coverage, have not

---

[468] Marmor & Oberlander, *supra* note 244.
[469] *Id.* at ¶ 5 & n.9.
[470] Oberlander & Marmor, *supra* note 39.

solved problems of unmet need.[471]

> We found that nearly a quarter of adults who were in fair or poor health reported being unable to see a doctor because of cost during the implementation of the reforms. We also found that state residents earning less than $25,000 per year were much less likely than higher earners to receive screening for cardiovascular disease and cancer.[472]

Marmor, Oberlander and White concluded that:

> [i]f the United States is to control health care costs, it will have to follow the lead of other industrialized nations and embrace price restraint, spending targets, and insurance regulation. Such credible cost controls are, in the language of politics, a tough sell because they threaten the medical industry's income. The illusion of painless savings, however, confuses our national debate on health reform and makes the acceptance of cost control's realities all the more difficult.[473]

Jacob Hacker argued that:

> Public health insurance emphasizes the broad sharing of risk, ensuring coverage that is affordable and of high quality for the small portion of the population that accounts for most health care spending. On the other hand, private plans are generally more flexible and more capable of building integrated provider networks, and they have at times moved into new areas of care management in advance of the public sector. In short, public and private plans have unique strengths, and both should have an important role in a reformed system.
>
> Healthy competition is about accountability. If public and private plans are competing on fair and equal terms, allowing enrollees to choose between the two will place a crucial check on each.
>
> . . . . Nearly all other advanced industrial democracies rely much more on public health insurance than the United States does, and all have lower health care costs per person, have seen their costs rise more slowly, and yet have maintained better overall health outcomes and much stronger health security for all their citizens.[474]

---

[471] Cheryl R. Clark et al., *Lack Of Access Due To Costs Remains A Problem For Some In Massachusetts Despite The State's Health Reforms*, 30 *HEALTH AFFAIRS 2247 (2011).*

[472] *Id.*

[473] *Obama Administration*, *supra* note 22, at 488.

[474] Jacob S. Hacker, *Healthy Competition – the Why and How of "Public-Plan Choice"*, 360 NEW ENG. J. MED. 2269, 2269–70 (2009); *see* Jacob S. Hacker, *Poor Substitutes – Why Cooperatives and Triggers Can't Achieve the Goals of a Public Option,* 361 NEW ENG. J. MED. 1617 (2009) (describing the "public option").

The Obama public option would have avoided "the marketing expenses of private insurance and the costs of medical underwriting (the process insurers use to decide whether to offer applicants coverage and to calculate premiums on the basis of health status). In addition, a public plan does not have to generate profits to reward its stockholders."[475] Its omission from the final legislation, though perhaps politically unavoidable, significantly reduces the likelihood that the Act will achieve real cost control.

B. Waste in the Health Care System

1. Introduction

Peter Orszag said in a 2009 interview:

> Estimates suggest that as much as $700 billion a year in healthcare costs do not improve health outcomes. They occur because we pay for more care rather than better care. We need to be moving towards a system in which doctors and hospitals have incentives to provide the care that makes you better, rather than the care that just results in more tests and more days in [the] hospital.[476]

Professor John E. Wennberg of Dartmouth Medical College has made a similar estimate:

> up to one-third of the over $2 trillion that we now spend annually on healthcare is squandered on unnecessary hospitalizations; unneeded and often redundant tests; unproven treatments; over-priced, cutting-edge drugs; devices no better than the less expensive products they replaced; and end-of-life care that brings neither comfort care nor cure.[477]

Consulting firm PricewaterhouseCoopers (PwC) said in a 2008 study that total waste could be as much as $1.2 trillion per year.[478] Why is the system so inefficient? According to a RAND Corporation study, "[i]nefficiencies persist within the health care system because- in contrast to other economic sectors in which

---

[475] *Obama Administration*, *supra* note 22, at 487.

[476] ROBERT KELLEY, THOMSON REUTERS, WHERE CAN $700 BILLION IN WASTE BE CUT ANNUALLY FROM THE U.S. HEALTHCARE SYSTEM? 3 (2009), *available at* www.factsforhealthcare.com/whitepaper/HealthcareWaste.pdf.

[477] *Id.*

[478] PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, THE PRICE OF EXCESS: IDENTIFYING WASTE IN HEALTHCARE SPENDING 1 (2010), *available at* http://www.kaiserhealthnews.org/~/media/Files/2010/May%20to%20September/pwcreport.pdf.

competition and other economic incentives act to reduce the level of waste- none of the health care system's players have strong incentives to economize."[479] In addition, as Victor Fuchs pointed out, "Every dollar of waste, fraud, and abuse is a dollar of income to someone in the system . . . . [A]bsolute cuts in spending will be resisted absolutely."[480]

2. What is Waste?

Waste has been defined as spending that can be eliminated without reducing quality of care (New England Health Institute) and activities or resources that do not add value (Institute of Medicine).[481]

Victor Fuchs differentiates between medical waste and economic waste:

> Medical waste is defined as any intervention that has no possible benefit for the patient or in which the potential risk to the patient is greater than potential benefit. Economic waste is defined as any intervention for which the value of expected benefit is less than expected costs. The proportion of care deemed wasteful using the medical definition is much smaller than that deemed wasteful using the economic definition . . . . Economic waste is much more common because of third-party payment. A conscientious clinician treating an insured patient would tend to recommend any intervention with a potential benefit greater than the potential risk.
>
> . . .
>
> Identification of waste is difficult, but eliminating it is more

[479] Tanya G.K. Bentley et al., RAND CORPORATION, *Waste in the U.S. Health Care System: A Conceptual Framework*, 86 MILBANK QUARTERLY, 629, 630 (2008).

[480] Victor R. Fuchs, *Reforming US Health Care: Key Considerations for the New Administration*, 301 J. AM. MED. ASS'N, 963, 964 (2009). He also wrote that: "The idea of sick patients shopping for the lowest-priced medical care (the way they buy automobiles) is a fantasy that will not contribute to informed elimination of waste. There seems to be no alternative to relying on physicians to practice more cost-effective care. There are 3 requirements for physicians to practice cost-effective care. First, physicians need information about effectiveness and costs; the range of possible diagnostic and therapeutic interventions available in all but the simplest cases is staggering . . . . Second, physicians require access to an infrastructure that provides specialized technology and personnel appropriate for cost-effective care . . . . Third, information and infrastructure will often be wasted unless physicians are provided with incentives that reward cost-effective decisions." Victor R. Fuchs, *Eliminating "Waste" in Health Care*, 302 J. AM. MED. ASS'N, 2481, 2482 (2009) [hereinafter *Eliminating "Waste" in Health Care]*.

[481] PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, *supra* note 478.

> difficult. Every dollar of waste is income to some individual or organization.[482]

Waste is an unnecessary cost and can increase the risk to patients of suffering or harm.[483] However, waste is difficult to eliminate, partly due to a lack of consensus as to whether a given practice is wasteful and partly because it is hard to bring systemic change to an enormous institution like the American health care system.[484] In addition, one person's waste is another person's profit margin.[485]

Waste includes paying for more care, not better care; unnecessary hospitalizations and readmissions; unnecessary or redundant tests; unproved treatments; end of life care that neither comforts nor cures; medical errors; fraud and abuse; services that do not contribute to better health outcomes; and inefficiencies in production of healthcare goods and services.[486] Experts classify waste as being behavioral, operational, or clinical.[487] Many studies do not include the behavioral component: costs resulting from obesity, physical inactivity, smoking, drug or alcohol abuse, or lack of exercise.[488] According to PwC, annual waste attributable to behavioral factors totals $303 to $493 billion; waste due to clinical factors, $312 billion; and operational waste $126 to $315 billion.[489]

Are expensive new drugs and devices better or just new? Most physicians are not well informed on drug effectiveness, and know little or nothing about the cost to the patient of different drugs that could be prescribed for a particular disease.

For example, a 2002 study found that newer drugs known as ACE

---

[482] *Eliminating "Waste" in Health Care*, *supra* note 480, at 2481–82.

[483] KELLEY, *supra* note 476, at 7.

[484] *Id.*

[485] Scott D. Danzis, Note, *Revising the Revised Guidelines: Incentives, Clinically Integrated Physician Networks, and the Antitrust Laws*, 87 VA. L. REV. 531, 564 n.146 (2001) (discussing how the traditional health care system encouraged waste by rewarding providers).

[486] David R. Riemer, *Follow the Money: The Impact of Consumer Choice and Economic Incentives on Conflict Resolution in Health Care*, 29 HAMLINE J. PUB. L. & POL'Y 423, 439–40 (2008); Joan H. Krauset, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J. L. & MED. 343, 362 & n.91, 363 (2010); Ani B. Satz, *The Limits of Health Care Reform*, 59 ALA. L. REV. 1451, 1495–96 (2008).

[487] PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, *supra* note 478, at 4–5.

[488] *Id.* at 6 (discussing behavioral risk factors including obesity, smoking, and alcohol abuse).

[489] *Id.* at 6.

> inhibitors and calcium channel blockers were no more effective than older diuretic medicines in controlling hypertension, despite costing thirty times as much. Similarly, a 2006 study found that second-generation anti-psychotic medications, priced at ten times the cost of older products, were no more effective than their predecessors.[490]

The same study cites another example:

> An illustration of this potential relates to the prescription of anticoagulant therapy for patients with atrial fibrillation. Despite publication of several research studies since 1989 indicating that this therapy reduces risk of ischemic stroke by 68 percent or more, anticoagulants are still not prescribed for most patients in whom such treatment is indicated.[491]

In a 2006 article, Gail Wilensky argued for creating a new comparative effectiveness center, but pointed out that "[b]etter information about the comparative effectiveness of various medical strategies and procedures might not, in itself, lead to better decision making in health care unless there is also a major change in financial incentives."[492]

3. Sources of Waste

According to PwC, the top 3 sources in terms of cost are: defensive medicine (up to $210 billion annually), inefficient claim processing (up to $210 billion), and care of preventable conditions related to overweight (up to $200 billion).[493] However, Professor Tom Baker argues that "[n]o one has a good handle on defensive medicine costs. Liability is supposed to change behavior, so some defensive medicine is good. Undoubtedly some of it may be unnecessary, but we don't have a good way to separate the two."[494] Doctors complain about having to practice defensively, but Baker says:

Doctors will say that. But when you dig down, you find that

---

[490] ELIZABETH DOCTEUR & ROBERT BERENSON, HOW WILL COMPARATIVE EFFECTIVENESS RESEARCH AFFECT THE QUALITY OF HEALTH CARE?, 8 (2010), *available at* www.urban.org/uploadedpdf/412040_comparative_effectiveness.pdf.

[491] *Id.* at 10.

[492] Gail R. Wilensky, *Developing a Center for Comparative Effectiveness Information*, 25 HEALTH AFF. 572, 583 (2006).

[493] PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INSTITUTE, *supra* note 478, at 1.

[494] Anne Underwood, *Would Tort Reform Lower Costs?*, N.Y. TIMES PRESCRIPTIONS BLOG (Aug. 31, 2009, 3:45 PM), http://prescriptions.blogs.nytimes.com/2009/08/31/would-tort-reform-lower-health-care-costs/.

what's really happening is that doctors tend to do what other doctors around them do. They go along with the prevailing standard of care in their region—which in many cases isn't even a state, but a city or county.[495]

According to Thomson Reuters,[496] major sources of waste include:

Unwarranted Use (40% of the total): this includes defensive medicine, excessive lab tests, high cost procedures for low risk patients, non-palliative end of life care, and the use of brand name instead of generic drugs.[497] Their estimate of the annual cost: $250 to $325 billion.[498]

> More than 95 million high-tech scans are done each year, and medical imaging, including CT, M.R.I. and PET scans, has ballooned into a $100-billion–a-year industry in the United States, with Medicare paying for $14 billion of that. But recent studies show that as many as 20% to 50% of the procedures should never have been done because their results did not help diagnose ailments or treat patients.[499]

According to the New England Health Institute (NEHI):

> Our analyses of the peer-reviewed literature showed that there is strong evidence that most of the antibiotics prescribed for the treatment of these [ear infections, sore throat, upper respiratory infections] are unnecessary, as these common infections are largely due to viruses that are not susceptible to antibiotics . . . . The data suggest that up to 55 percent of antibiotic prescriptions are medically unnecessary and could be avoided, resulting in annual savings of $1.1 billion.[500]

Fraud and Abuse (19% of the total): estimated annual cost $125 to $175 billion.[501] The FBI has estimated "that fraudulent billings to public and private healthcare programs were 3–10 percent of total health spending, or $75 to $250 billion, in fiscal year 2009."[502] In March 2010, President Obama "order[ed] a

---

495 *Id.*

496 KELLEY, *supra* note 476, at 8.

497 *Id.* at 13, 25.

498 *Id.* at 13.

499 Gina Kolata, *Good or Useless, Medical Scans Cost the Same*, N.Y. TIMES, Mar. 1, 2009, http://www.nytimes.com/2009/03/02/health/02scans.html?_r=2.

500 JULES DELAUNE & WENDY EVERETT, NEW ENGLAND HEALTHCARE INST., WASTE AND INEFFICIENCY IN THE U.S. HEALTHCARE SYSTEM: CLINICAL CARE: A COMPREHENSIVE ANALYSIS IN SUPPORT OF SYSTEM-WIDE IMPROVEMENTS 20 (Wendy Everett & Nick King, eds., 2008).

501 KELLEY, *supra* note 476, at 18, 25.

502 Lewis Morris, *Combating Fraud in Health Care: An Essential Component of Any Cost Containment Strategy*, 28 HEALTH AFF. 1351, 1351 (2009).

crackdown on Medicare and Medicaid waste and fraud."[503]

Administrative Inefficiencies (17% of the total): estimated annual cost $100 to $150 billion.[504] Studies of the expected cost savings if the United States were to change to a single-payer system, in 2006 dollars, range from $89 billion to $280 billion.[505] "The average U.S. hospital spends one-quarter of its budget on billing and administration, nearly twice the average in Canada. American physicians spend nearly eight hours per week on paperwork and employ 1.66 clerical workers per doctor, far more than in Canada."[506] Health administration costs are 31% of healthcare expenditures in the United States, as compared to 16.7% in Canada.[507] A reduction from 31% to 25% would save $126 billion annually.[508]

Provider Inefficiency and Errors (12% of the total): estimated annual cost $75 to $100 billion.[509]

> [I]nefficient production processes are likely to play a major role in driving health spending disparities between the United States and other industrialized nations with a similar overall quality of performance. For example, medical errors—which can indicate inefficient processes—are estimated to cost between $17 billion and $29 billion annually in the United States, compared with an estimated $750 million per year in Canada.[510]

Lack of Coordination of Care (6% of the total): estimated annual cost $25 to $50 billion.[511] Most Americans have numerous health care providers.[512] When providers do not coordinate their services, the resulting inefficiencies are expensive and potentially harmful.[513] Examples include duplicate tests; inappropriate treatment because relevant treatment is not accessible; patients are forced to use the emergency room because other services are unavailable; and

---

503 Helene Cooper & Robert Pear, *Obama Gets Tough on Health Care Fraud*, N.Y. TIMES, Mar. 10, 2010, http://www.nytimes.com/2010/03/11/health/policy/11health.html?_r=1.

504 KELLEY, *supra* note 476, at 9, 25.

505 Bentley et al, *supra* note 479, at 635–36.

506 KELLEY, *supra* note 476, at 9.

507 *Id.* at 9.

508 *Id.*

509 *Id.* at 10, 25.

510 Bentley et al, *supra* note 479, at 641.

511 KELLEY, *supra* note 476, at 12, 25.

512 *See id.* at 12 (noting that healthcare providers including emergency rooms, medical staff, and nursing homes lack coordination and that inefficiencies arise due to these numerous healthcare providers).

513 *Id.*

adverse drug reactions that occur because the prescribing physician does not have a full record of a patient's medications and drug reactions.[514]

Preventable Conditions and Avoidable Care (6% of the total): estimated annual cost $25 to $50 billion.[515] A glaring example is hospitalization or other acute care that becomes necessary because of lack of access to outpatient care.[516] "The number of hospitalizations for potentially avoidable conditions increased from 3.1 million in 1990 to 3.6 million in 1997. This was 13 percent of all hospitalizations in 1990 (excluding women with deliveries, newborn infants, and psychiatric admissions), but 15 percent in 1997."[517] In 2006, hospital costs for potentially preventable conditions totaled 10% of total hospital expenditure, and 18 percent of Medicare admissions were for potentially preventable conditions.[518]

4. Tort Reform

Comments often stress the direct and indirect costs resulting from the inefficient American tort system.[519]

> A process that takes an average of 4 to 5 years to reach verdicts, leaving injured patients in financial limbo, and allocates an enormous percentage of overall premium dollars to "frictional costs" (payments to lawyers, expert witnesses, and administrative entities), not to injured patients, obviously needs greater efficiency and rationality.[520]

Perhaps 95% of patients injured by negligent care never see a dime: payments are made in 25% of frivolous claims and are not made in 25% of good claims.[521] Only about 2% of malpractice incidents result in a lawsuit: physicians think the rate is 30% to 60%.[522] In addition to high malpractice insurance premiums, the

514 *Id.*

515 *Id.* at 16, 25.

516 *Id.* at 16.

517 *Id.* (quoting KOZAK ET AL., ACAD. FOR HEALTH SERV. RESEARCH AND HEALTH POLICY, NATIONAL TRENDS IN POTENTIALLY AVOIDABLE HOSPITALIZATIONS 17 (2000)).

518 *Id.*

519 *See generally* William B. Millard, *Elephants, Blind Sharpshooters, Golddiggers, and Beyond: The Prospects for Constructive Tort Reform*, 50 ANNALS OF EMERGENCY MED. 59 (2007) (discussing the financial and social costs associated with the current tort system).

520 *Id.* at 60.

521 *Id.* at 61.

522 *Id.* at 62.

system is said to encourage doctors to practice defensive medicine, thus inflating health care costs by the provision of unnecessary services.[523] Two broad types of tort reform have been discussed:

(1) Caps on payments: pain & suffering; punitive damages; contingency fees; reduced awards where there is evidence of other income.[524] Nearly 30 states already have laws: 26 states limit non-economic damages; 6 limit total damages.[525] Courts in 16 states have upheld these laws: courts in 11 states have overturned them, most recently the Illinois Supreme Court on February 4, 2010.[526] The laws have reduced payouts to plaintiffs and their lawyers, but have had little effect on malpractice premiums.[527]

(2) Limits on liability: shorter limitations periods; restricting liability to institutions; restrictions on joint and several liability.[528]

A Congressional Budget office (CBO) letter sent to Senator Hatch on October 9, 2009 said that tort reform could reduce total spending by 0.5%, $11 billion in 2009.[529] Reform could reduce federal health spending by $41 billion over 10 years and increase tax revenues by $13 billion.[530] Consulting firm Towers Perrin said that medical malpractice tort costs were $30.4 billion in 2007, 1% to 1.5% of total medical costs.[531]

Several other ideas have been floated: specialized health courts, where decisions are made by people with medical expertise rather than by lawyers; a focus on avoidance of injury, not personal negligence; and using a no-fault system, such as workers' compensation, as a model.[532]

It is clear that tort reform is not a magic bullet.

---

[523] *See* Kevin Sack, *Illinois Court Overturns Malpractice Statute*, N.Y. TIMES, Feb. 4, 2010, at A13; *see also* KELLEY, *supra* note 476, at 13.

[524] Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Hon. Orrin G. Hatch, U.S. Senate, 1–2 (Oct. 9, 2009), *available at* http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf. [hereinafter CBO Letter to Orrin Hatch].

[525] Millard, *supra* note 519, at 59.

[526] Sack, *supra* note 523.

[527] *See id.*

[528] CBO Letter to Orrin Hatch, *supra* note 524, at 2; Millard, *supra* note 519, at 60.

[529] CBO Letter to Orrin Hatch, *supra* note 524, at 3.

[530] *Id.* at 4–5.

[531] Underwood, *supra* note 494.

[532] Millard, *supra* note 519, at 60, 62.

C. Comparative Effectiveness, Quality of Care and Prevention

1. Comparative Effectiveness

The 2009 stimulus legislation, the American Recovery and Reinvestment Act (ARRA), included more than $1 billion for "comparative effectiveness research" (CER).[533] In ARRA, the Congress created the Federal Coordinating Council for Comparative Effectiveness Research to coordinate CER and related health services research across the federal government.[534] The belief is that, by increasing funding for CER, and making the results available to providers, treatment decisions will be improved.[535]

Under an aggressive approach, doctors who follow government approved best practices would be paid more and get good ratings.[536] The President's close advisors have included some who advocate nudges (e.g., Cass Sunstein) and those who advocate mandates (e.g., Peter Orszag).[537] Past efforts to set best practices have often failed.[538] Best practices are often controversial: e.g., the recent task force report on mammography.[539] There is no painless cost control.

According to one recent study,

> The Institute of Medicine (IOM) estimates that only half of the treatments and services that comprise standard medical care have been proven to be effective. And even where a treatment has been proven effective, the degree to which it is more effective than alternative treatments, and the circumstances in which it constitutes a more effective treatment, is often unknown . . . . Furthermore, the information generated through the research is

533 DOCTEUR & BERENSON, *supra* note 490, at 1.

534 *Id.*

535 *Id.* at 1–2.

536 Jerome Groopman, *Health Care: Who Knows 'Best'?,* N.Y. REV. OF BOOKS (Feb. 11, 2010) (book review).

537 Beware the Health Care 'Nudge', FIX HEALTH CARE POLICY (Aug. 31, 2009), http://fixhealthcarepolicy.com/research/beware-the-health-care-nudge; Philip Klein, *Orszag Compares Insurance Mandate to Seat Belt Laws*, AMSPECBLOG (Dec. 2, 2009, 1:50 PM), http://spectator.org/blog/2009/12/02/orszag-compares-insurance-mand.

538 Groopman, *supra* note 536.

539 *See* A. ALAN MOGHISSI, DENNIS K. MCBRIDE & MATTHEW AMIN, INST. FOR REG. SCI., MAMMOGRAPHY CONTROVERSY: WHO IS RIGHT? (2009), *available at* http://www.nars.org/Voice_of_Science_Articles/Mammography%20Controversy.pdf (describing the passionate opposition the U.S. Preventive Services Task Force faced from many health organizations upon releasing their recommendations).

> not always used in health-care decisionmaking [sic], both because the comparisons may not be particularly clinically relevant and because such information is not collected and disseminated systematically. Much of standard practice thus reflects tradition, expert opinion, training, marketing or some combination thereof, rather than application of evidence derived from research related to specific health care options.[540]

As the study points out, CER has often been controversial, particularly when it threatened doctors' income (e.g., recommendations for treatment of lower-back pain, based on findings that the outcomes from surgery were no better than those obtained from medical management of the condition).[541]

Sir Michael Rawlins, of the United Kingdom's National Institute for Health and Clinical Excellence, highlighted four challenges:

(1) the dearth of direct comparative effectiveness studies between interventions; (2) the limitations in applying the results from clinical trials to the real world; (3) the translation of clinical effectiveness into value; and (4) the complexities of drawing conclusions that are based, in part, on considerations of cost-effectiveness.[542]

As Docteur and Berenson point out, unlike countries that have a larger government role in the financing and delivery of health services (Canada and Europe), the United States has no formal infrastructure to make use of CER to promote evidence-based care: "[T]o a greater extent than exists in many other countries, the ability of both public and private to restrict coverage for a service on the basis of evidence that it is less effective than others, less cost-effective than others, or even ineffective, is relatively limited."[543] In the major 2003 Medicare legislation, Congress severely limited the use of CER in making coverage and reimbursement decisions under Medicare.[544]

Another factor is that medical practice is very slow to respond to new research findings: one study found that the time lag between the discovery of more effective forms of treatment and their inclusion in routine patient care averaged seventeen

---

[540] DOCTEUR & BERENSON, *supra* note 490, at 3.

[541] *Id.* at 5.

[542] PIERRE L. YOUNG, LEIGHANNE OLSEN & J. MICHAEL MCGINNIS, VALUE IN HEALTH CARE: ACCOUNTING FOR COST, QUALITY, SAFETY, OUTCOMES, AND INNOVATION 19 (2010), *available at* www.nap.edu/catalog/12566.html.

[543] DOCTEUR & BERENSON, *supra* note 490, at 6.

[544] *Id.* at 1.

years.[545] One horrifying example:

> relates to the importance of caregivers' [sic] washing their hands prior to patient contact, which was found to reduce infection and deaths as early as the 1840s. Despite prominent research and broad media coverage citing tens of thousands of deaths annually attributed to hospital-acquired infections, compliance with hand washing standards in hospitals ranges from 30 to 50 percent.[546]

One concern is that CER will result in rationing of expensive treatments, even if they are effective, either for everyone or for potentially vulnerable groups, such as Medicare and Medicaid beneficiaries.[547] In the current recession, with an increasing number of Americans either underinsured or uninsured, and at severe risk of financial disaster if they become sick, the cost of health care is not wholly a matter of personal choice.[548] Even where the care is not paid for directly by one of the increasingly stressed public systems, such as Medicare or Medicaid, the cost of employer-sponsored health care, for those lucky enough to have it, is heavily subsidized by the tax system.[549]

> Despite the current enthusiasm for its potential, undertaking comparative effectiveness research alone does not necessarily save money; the savings depend on the uncertain effect such research has on insurers' coverage decisions for medical technologies and on changes in medical practice . . . . A 2008 CBO report estimated that an initiative to fund comparative effectiveness research would reduce national health care spending only 'by an estimated $8 billion over the 2010–2019 period (or by less than one tenth of 1%).'
>
> Similarly, the potential for prevention to generate cost savings is often exaggerated . . . . '[O]ver the past 4 decades, hundreds of studies have shown that prevention usually adds to medical spending.'
>
> . . .
>
> . . . At this point, we lack evidence that paying providers on the basis of outcomes will reduce spending on medical care.[550]

---

[545] E.A. Balas & S.A. Boren, *Managing Clinical Knowledge for Health Care Improvement*, *in* YEARBOOK OF MEDICAL INFORMATICS 66 (J. Bemmel & A.T. McCray eds., 2000); *see* DOCTEUR & BERENSON, *supra* note 490, at 2.

[546] DOCTEUR & BERENSON, *supra* note 490, at 7.

[547] *See* Richard M. Friedenberg, *Rationing in Health Care: Changing the Patterns of Health Care,* RADIOLOGY, Apr. 2003, at 5, *available at* http://radiology.rsna.org/content/227/1/5.full.pdf+html.

[548] *See* ROBERT MOSS, FIXING THE AMERICAN HEALTH CARE SYSTEM 2 (2010), *available at* http://webs.wofford.edu/mossre/COS/moss_paper.pdf.

[549] *See Id.* at 19.

[550] *Obama Administration*, *supra* note 22, at 486.

2. Accountable Care Organizations

Under the Act, ACOs are to be set up as provider-led pilot projects that are accountable for overall costs and quality of care.[551] Insurers will be heavily involved as they may be primary sources of funding and they will control payments to the organizations.[552] "In almost every region of the country, hospitals and physicians are forming (or talking about forming) accountable care organizations (ACOs) and entering into other arrangements designed to integrate care, manage chronic conditions, and enable evidence-based practices."[553]

3. The Act's Provisions on Value and Quality

The Act does not address waste as a discrete issue, but includes numerous provisions that aim to improve value and the quality of care which, if successful (a big if), will reduce the amount of wasteful spending.

The Act includes quality adjusted payments, a national strategy to improve health care quality,[554] an interagency working group on health care quality,[555] development of quality measures,[556] and the use of quality measures and efficiency measures.[557] The Act creates a new Center for Medicare and Medicaid Innovation, to test new payment and patient care models.[558]

The Act creates a shared savings program for "accountable care organizations" that provide high quality and/or lower costs;[559] requires the Secretary to develop a national voluntary pilot program encouraging bundled payment models;[560] creates an independence at home demonstration project;[561] creates a

551 *See* Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, NEW ENG. J. MED. (Dec. 22, 2010), http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404.

552 *See id.*

553 *Id.* at 1.

554 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3011, 124 Stat. 119, 378–80 (2010) (codified at 42 U.S.C. § 280j).

555 *Id.* § 3012 (codified at 42 U.S.C. § 280j).

556 *Id.* §§ 3013, 10303 (codified at 42 U.S.C. §§ 299b, 299c, 1395aaa).

557 *Id.* §§ 3014, 10304 (codified at 42 U.S.C. § 1395aaa).

558 *Id.* §§ 3021, 10306 (codified at 42 U.S.C. § 1315a,)

559 *Id.* §§ 3022, 10307 (codified at 42 U.S.C. §§ 1315a, 1395jjj).

560 *Id.* §§ 3023, 10308 (codified at 42 U.S.C. § 1395cc-4).

561 *Id.* § 3024 (codified at 42 U.S.C. § 1395cc-5).

hospital readmissions reduction program;[562] creates a community-based care transitions program;[563] and extends the gain-sharing demonstration project through September 30, 2011.[564] The Act establishes procedures for conducting research and implementing a model for quality improvement in health care delivery.[565]

The Act establishes a new program to provide grants or contracts to enable the implementation of medication therapy management services, provided by pharmacists, for individuals who are at high-risk of medication-related complications, have two or more chronic diseases, take high-risk medications, or take 4 or more of any kind of medication.[566]

The Act includes several provisions that link quality of outcomes to the amount paid by Medicare.[567] The Act adjusts the amount of payments to most types of Medicare provider to improve payment accuracy.[568] The Act also includes provisions to promote program integrity.[569]

The Act establishes a value-based purchasing program for most hospitals.[570] For hospital discharges after October 1, 2012, a portion of a hospital's Medicare payment will be based on the hospital's performance on quality measures related to common and high-cost conditions, including cardiac, surgical and pneumonia care.[571] Under the Act, quality measures will be developed with input from external stakeholders.[572] Demonstration programs will be established for inpatient critical access hospitals and other hospitals excluded from the value-based purchasing program.[573]

The Secretary of HHS is required to submit a plan to Congress describing how to adopt a value-based purchasing system for skilled nursing facilities and home health agencies.[574] The Secretary is also required to develop and implement a budget-

[562] *Id.* § 3025 (codified at 42 U.S.C. § 1395ww).
[563] *Id.* § 3026 (codified at 42 U.S.C. § 1395b-1).
[564] *Id.* § 3027 (codified at 42 U.S.C. § 1395ww).
[565] *Id.* § 3501 (codified at 42 U.S.C § 299b-33, 299b-34).
[566] *Id.* § 3503 (codified at 42 U.S.C. § 299b-35).
[567] *Id.* §§ 3001–08 (codified in scattered sections of 42 U.S.C.).
[568] *Id.* §§ 3131–33 (codified in scattered sections of 42 U.S.C.).
[569] *Id.* §§ 6001–05 (codified in scattered sections of 42 U.S.C.).
[570] *Id.* § 3001 (codified at 42 U.S.C. § 1395ww).
[571] *Id.*
[572] *Id.*
[573] *Id.*
[574] *Id.* § 3006.

neutral payment system, for services provided after 2015, to adjust Medicare payments to physicians, based on the quality and cost of the care that they provide.[575] After 2017, the Secretary may apply the modifier to other professionals.[576] Payments under the Physician Quality Reporting Incentive are extended through 2014, and, beginning in 2015, there will be a reduction in payments to physicians who do not submit measures to PQRI.[577]

The Act expands the physician resource use feedback program[578] and provides for the Secretary to create a website that will contain information on physicians and other professionals who participate in Medicare.[579]

Quality reporting measuring programs will be implemented for long term care hospitals, inpatient rehabilitation hospitals, hospice providers, inpatient psychiatric hospitals and cancer hospitals.[580] Providers who do not participate will be subject to payment reductions.[581]

Beginning in fiscal year 2015, inpatient hospitals in the highest twenty-fifth percentile of rates of hospital-acquired conditions for certain high-cost and common conditions will be subject to a payment penalty.[582]

A new nonprofit entity, the Patient Centered Outcomes Research Institute, will carry out a CER agenda, starting in 2010.[583] By 2015, total annual funding for the Institute will be nearly $500 million.[584] The Act bars the government from using findings as the sole basis for decisions about what Medicare will cover.[585]

> The Patient-Centered Outcomes Research Institute . . . shall not develop or employ a dollars per quality adjusted life year (or similar measure that discounts the value of a life because of an

[575] *Id.* § 3007 (codified at 42 U.S.C. § 1395w-4).
[576] *Id.*
[577] *Id.* § 3002 (codified at 42 U.S.C. § 1395w-4(a), (m)).
[578] *Id.* § 3003 (codified at 42 U.S.C. § 1395w-4).
[579] *Id.* § 10331 (codified at 42 U.S.C. § 1395w-5).
[580] *Id.* §§ 3004, 3005, 10322 (codified at 42 U.S.C. § 1395).
[581] *Id.* §§ 3004, 10322 (codified at 42 U.S.C. § 1395).
[582] *Id.* § 3008 (codified at 42 U.S.C. § 1395ww).
[583] *Id.* §§ 6301, 10602 (codified at 42 U.S.C. § 1320e).
[584] *Overview of the Patient-Centered Outcomes Research Institute*, CENTER FOR MED. TECH. POL'Y, http://www.cmtpnet.org/comparative-effectiveness/overview-of-the-patient-centered-outcomes-research-institute (last visited May, 15 2011).
[585] Patient Protection and Affordable Care Act §§ 6301 (codified at 42 U.S.C. § 1320e-1).

> individual's disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.[586]

The specific duties of the Institute are to: "[e]stablish an objective research agenda; [d]evelop research methodological standards; [c]ontract with eligible entities to conduct the research; [e]nsure transparency by requesting public input; and [d]isseminate the results to patients and healthcare providers."[587]

IX. LEARNING FROM OTHER COUNTRIES

The problem of increasing health care costs is not limited to the United States:

> Almost everywhere, health care became relatively more expensive as public budgets were more constrained – but how much more expensive and how much more constrained has varied substantially between countries. These pressures, in turn, are mediated by different sets of actors and institutions. It is important to note that debates over controlling health care expenditures took place everywhere, regardless of actual levels or growth rates of health spending . . . . As a former official of the OECD's health policy unit claimed, '[T]he delivery and finance of healthcare vary between nations more than any other public policy.'[588]

One of the ironies of the recent debates over health care reform and Social Security privatization has been that, while proponents of individual accounts under Social Security point to Chile as a shining example, they are unwilling to accept that the United States has anything to learn from other countries' health systems, even that of Canada, a country with which we have far more in common than we do with Chile.[589]

---

586 Peter J. Neumann & Milton C. Weinstein, *Legislating Against Use of Cost-Effectiveness Information*, 363 NEW ENG. J. MED. 1495, 1495 (2010), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1007168.

587 *Overview of the Patient-Centered Outcomes Research Institute*, *supra* note 584.

588 Ted Marmor et al., *Comparative Perspectives and Policy: Learning in the World of Health Care*, 7 J. COMP. POL'Y ANALYSIS 331, 338 (2005) (internal citations omitted), *available at* http://www.law.harvard.edu/programs/petrie-flom/PDFs/marmorFEB25.pdf.

589 *See* Claudia Sanmartin et al., *Comparing Health and Health Care Use in Canada and the United States*, 25 HEALTH AFF. 1133, 1140 (2006), *available at* http://content.healthaffairs.org/content/25/4/1133.full.pdf+html;

National health care spending in 2009 was 17.6% of gross domestic product (GDP), according to the Center of Medicare and Medicaid Services Office of the Actuary.[590] Not only does the U.S. spend more per capita on health care, it has one of the highest growth rates and does not achieve better outcomes on many important health measures.[591] In the U.S., the share of GDP spent on health care increased from 8.8 percent in 1980 to 15.2 percent in 2003.[592] The next highest were Switzerland at 11.6 percent and Germany at 10.8 percent.[593] In Organization for Economic Cooperation and Development (OECD) countries with above average per capita income, spending in 2003 ranged from $ 2,104 in Finland to $ 5,711 in the U.S. The next highest were Luxembourg at $ 4,611 and Switzerland at $ 3,847.[594] Canada spent $ 2,998.[595]

The United States cannot simply copy the health care system of another country.[596] One major difference, that cannot be ignored, is that "[t]he United States places greater emphasis on individual responsibility, free choice, and pluralism, whereas other industrialized nations focus on preserving equitable access to health care for the entire population."[597] In addition, as Laurene Graig pointed out in 1999, "[t]hough the share of U.S. health expenditures covered by public financing has increased from 42 percent in 1990 to 46 percent today, it is still below the average of nearly 75 percent in the other nations analyzed in this book."[598]

---

see also Geoffrey Kollman, *Social Security: The Chilean Example*, NAT'L L. CENTER INTER-AM. FREE TRADE (1998), http://www.natlaw.com/pubs/spchlb1.htm.

590 Centers for Medicare & Medicaid Services, supra note 47; *see Health Care Spending in the United States and OECD Countries,* KAISER FAM. FOUND. (Jan. 2007), http://www.kff.org/insurance/snapshot/chcm010307oth.cfm.

591 *Id.*

592 *Id.*

593 *Id.*

594 *Id.*

595 *Id.*

596 *See* Karen Davis et al., *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, THE COMMONWEALTH FUND (May 15 2007), http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/May/Mirror--Mirror-on-the-Wall--An-International-Update-on-the-Comparative-Performance-of-American-Healt.aspx (discussing that given the numerous variables that affect U.S. health care, improvements in U.S. health care systems can be achieved by drawing upon the best practices of leading countries around the world).

597 GRAIG, *supra* note 12, at 7.

598 *Id.* at 178–79.

However, we can learn from other countries: "the point is that by examining other people's experiences you can extend your range of perceptions of what is possible."[599]

The country from which the United States can learn most is Canada:

> [I]f it is possible, in a society not identical but roughly comparable to ours, to provide comprehensive medical care at 2 percent less of GNP than we now spend, there would appear to be a very good basis for believing that we are spending more than necessary.
>
> . . . [T]here is a third way between the British example of severe service rationing in some areas and the American way of continued high spending on medical care. That third way is the Canadian route to cost containment—compatible with decent access to medical care.
>
> . . . The central lesson of the Canadian experiment is that the balance among cost, quality, and access is relatively easy to evaluate. What Canada illustrates clearly is that a sensibly organized national health insurance system can work in a political community like that in the United States; that universal coverage, coherent financial responsibility, and clear political accountability are the central ingredients of success; and that a population accustomed to the same standard of medical care as the United States can take pride in what in essence are ten provincial Blue Cross/Blue Shield plans with comprehensive benefits to which everyone belongs as a matter of right.[600]

Laurene Graig noted in 2007 that:

> Nations that provide universal coverage to their populations have accomplished this through a combination of compulsion and subsidization; individuals are required to have health insurance, insurers are required to cover everyone, and cross-subsidization across risk groups allows the entire population to have health insurance coverage.
>
> The United States has not yet reached this point because it does not accept compulsion and subsidization—the two basic premises of social insurance. Ideological factors come into play, as national health insurance is denounced by many Americans as a form of socialism – although national health insurance was introduced in

[599] Robert Evans, *The Spurious Dilemma: Reconciling Medical Progress and Cost Control*, 4 HEALTH MATRIX 1, at 26 (1986).

[600] UNDERSTANDING HEALTH CARE REFORM, *supra* note 1, at 118, 194; *see also* GREGORY P. MARCHILDON, HEALTH SYSTEMS IN TRANSITION: CANADA (Sarah Allin & Elias Mossialos eds., Univ. of Toronto Press, 2005) (noting the success of the Canadian healthcare system through its funding, mandatory coverage and balance of governmental supervision).

Germany and Japan as an antidote to the spread of socialism.[601]

Other rich democracies use purchasing power to control costs.[602] In Canada and Sweden, where medical costs are part of the public budgets, "officials have powerful incentives to restrain increases in medical costs to avoid reducing the funds for other public programs or having to raise taxes."[603] In other countries, such as Germany and France, the governments regulate insurers and help them control costs.[604]

Numerous studies have found that the "prices of care, not the amount of care delivered, are the primary differences between the United States and other countries . . . . [T]he United States has excess administrative costs that are substantially higher than those of other rich democracies."[605]

> Effective cost control requires strong government leadership to set targets or caps for spending in the various sectors of medical care (hospital, pharmaceutical, and physicians), either directly or through insurers. The targets may not always be binding, and these caps would be on total expenditures, not services. But without explicit targets and continual efforts to enforce them, no health care system can control costs.[606]

In 1990, Morone wrote about Canada's adoption of universal health insurance in terms that predict the controversy surrounding the Act:

> It is difficult to imagine a lesson that is more foreign to the American experience. Instead of hard conscious choices, we have sought painless automatic solutions . . . . [T]he [Canadian] lessons . . . are not just different—they challenge the central features of American political culture, at least as they have manifested themselves in health care policy.[607]

A single payer plan would displace the private insurance industry, and is not politically feasible in the United States.[608] However, there are other approaches that provide more robust cost control than the Act:

> Other countries that have multiple insurers, such as Germany,

---

601 GRAIG, *supra* note 12, at 177 (citation omitted).

602 *Obama Administration*, *supra* note 22, at 487.

603 *Id.*

604 *Id.*

605 *Id.*

606 *Id.* at 488.

607 James A. Morone, *American Political Culture and the Search For Lessons From Abroad*, 15 J. HEALTH POL. POL'Y & L. 129, 141 (1990).

608 *See id.* (stating that politicians find it easier to propose hidden taxes that shift the burden to employers by mandating employee benefits).

> Japan, and the Netherlands, use all-payer regulation to control costs. In these countries, insurers come together to negotiate, or the government takes the lead in setting, common payment rules for medical care. With a few exceptions, payments to all doctors in a given geographic area follow a standard fee schedule. Hospitals are also paid on comparable terms.[609]

Such a system has significant advantages: prices are significantly lower than in the U.S.; the system can include system wide spending targets; it "reduces concerns that costs will be shifted rather than reduced and would create a fairer payment system;" standard rules simplify billing and reduce administrative costs; and a public plan and private plans could coexist.[610]

X. THE COST OF REFORM AND THE COST OF REPEAL

According to health economist Jonathan Gruber,

> At the peak of its effect on spending, in 2016, the law will increase health care expenditures by about 2%; by 2019, the ACA-related increase will be 1%, or 0.2% of the GDP. However, these increases are quite small relative to the gains in coverage under the new law. There are currently 220 million insured Americans, and the CMS predicts that 34 million more will be insured by 2019. The agency also estimates that without this reform, health care costs would grow by 6.6% per year between 2010 and 2019. So we'll be increasing the ranks of the insured by more than 15% at a cost that is less than one sixth of 1 year's growth in national health care expenditures.[611]

The CMS estimates "imply that by the second decade, the ACA will have reduced national health care spending."[612]

In a 2009 study, the Robert Wood Johnson Foundation found that,

> Under a range of economic scenarios, the analysis shows an increasing strain on business owners and their employees over the next decade if reform is not enacted. There would be a dramatic decline in numbers of people insured through their employers, and millions more would become uninsured. There would be large

609 Jonathan Oberlander & Joseph White, *Systemwide Cost Control – The Missing Link in Health Care Reform*, NEW ENG. J. MED., Sept. 2, 2009, *available at* http://healthpolicyandreform.nejm.org.

610 *Id.*

611 Jonathan Gruber, *The Cost Implications of Health Care Reform,* NEW ENG. J. MED., June 3, 2010, *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1005117.

612 *Id.*

> growth in enrollment in public programs, major increases in health care spending and growing levels of uncompensated care. While all income levels would be affected, middle-class working families would be hardest hit.[613]

The report found also that

> Individual and family spending would increase significantly–from $326.4 billion in 2009 to $548.4 billion in 2019 in the worst case scenario, and to $478.2 billion in the best case.
>
> Medicaid and CHIP spending would grow substantially, both because of increased enrollment and because of higher health care costs. In the worst case scenario, Medicaid and CHIP spending for the non-elderly would increase from $251.2 billion in 2009 to $519.7 billion in 2019. In the best case, spending would increase 61.7 percent to $403.8 billion.[614]

On January 19, 2011, the House of Representatives approved, on a near party-line 245-189 vote, legislation to repeal the Act.[615] Only three Democrats voted for the bill.[616] On February 2, 2011, the Senate voted amendments to the Federal Aviation Administration reauthorization regarding the Act.[617] The Senate voted on party lines, 51-47, to reject an amendment offered by Senate Republicans to repeal the entire Act.[618]

---

[613] JOHN HOLAHAN ET AL., HEALTH REFORM: THE COST OF FAILURE 1 (2009), *available at* http://www.rwjf.org/files/research/costoffailure20090529.pdf.

[614] Id. at 2. A 2010 Commonwealth Fund report made similar findings:

> Absent successful implementation of the Affordable Care Act and the spread of reforms to private insurance markets and to other public payers, we project that, if historical trends continue, national per-person spending on health insurance premiums will increase 79 percent from 2010 to 2020, or an average of 5.4 percent annually. In recent years, per-person spending increases in most states have followed national trends. Using these national projections, and applying the same rate of increase to all states, average total family premiums would reach $17,906 by 2015 and $23,342 by 2020 . . . . Projections for family premiums in 2020 range from $19,654 in Arkansas to $26,380 in Massachusetts.

CATHY SCHOEN ET AL., STATE TRENDS IN PREMIUMS AND DEDUCTIBLES, 2003–2009: HOW BUILDING ON THE AFFORDABLE CARE ACT WILL HELP STEM THE TIDE OF RISING COSTS AND ERODING BENEFITS 6 (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Dec/1456_Schoen_state_trends_premiums_deductibles_20032009_ib_v2.pdf.

[615] Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (as passed by House, Jan. 19, 2011).

[616] Jerry Geisel, *House Passes Repeal of Health Care Reform Law*, BUS. INS. (Jan. 19, 2011, 5:02 PM), http://www.businessinsurance.com/article/20110119/BENEFITS11/110119896.

[617] FAA Air Transportation Modernization and Safety Improvement Act, S. 223, 112th Cong. (2011) (as passed by Senate, Feb. 2, 2011).

[618] David M. Herszenhorn, *Senate Rejects Repeal Of Health Care Law*, N.Y. TIMES, Feb. 3, 2011, http://www.nytimes.com/2011/02/03/health/policy/

The House bill, which is only two pages long, is subtly entitled: Repealing the Job-Killing Health Care Law Act.[619] In voting for repeal, Republicans essentially ignored a Congressional Budget Office (CBO) analysis finding that repeal would increase the federal budget deficit by a total of $145 billion from 2012 to 2019, and by $230 billion from 2012 to 2021.[620] The CBO also said that the repeal bill "would increase federal deficits in the decade after 2019 by an amount that is in a broad range around one-half percent of GDP."[621] Republicans said that the CBO analysis is flawed because it includes only six years of benefits under the law, and does not include the cost to fix Medicare's physician payment system.[622] At a January 26, 2011, House Budget Committee hearing, Paul Van de Water of the Center on Budget and Policy Priorities said that claims (that the CBO's projections are faulty) are groundless.[623]

Republicans have said that the law is unaffordable.[624] "I don't think anybody in this town believes that repealing Obamacare is going to increase the deficit," Speaker John Boehner told

03congress.html.

619 Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (as passed by House, Jan. 19, 2011).

620 *Compare* JOHN BOEHNER ET AL., OBAMACARE: A BUDGET BUSTING, JOB KILLING HEALTH CARE LAW 2, 12 (2011), *available at* http://speaker.gov/UploadedFiles/ObamaCareReport.pdf (rejecting the Congressional Budget Office Analysis of a budget reduction as a result of the Act), *with* Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Hon. John Boehner, Speaker of the House (Jan. 6, 2011), *available at* http://www.cbo.gov/doc.cfm?index=12040 (noting that the House GOP repeal bill would increase deficit $230 billion over ten years), *and* Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Hon. Nancy Pelosi, Speaker of the House (Mar. 20, 2010), *available at* http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf (noting that enactment of the Affordable Health Care Act would net reductions in the federal deficit). On December 22, 2010, the CBO released a publication containing its cost estimates for the health care reform law. *See* CONGRESSIONAL BUDGET OFFICE, Pub. No. 4228, SELECTED CBO PUBLICATIONS RELATED TO HEALTH CARE LEGISLATION, 2009-2010 4–5 (2010), *available at* http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf.

621 Letter from Douglas W. Elmendorf to John Boehner, *supra* note 620, at 7

622 BOEHNER ET AL., *supra* note 620, at 12–14.

623 Paul Van de Water, *Testimony: Paul Van de Water, Senior Fellow, Before the Committee on the Budget*, CENTER ON BUDGET AND POL'Y PRIORITIES (Jan. 26, 2011), http://www.cbpp.org/cms/?fa=view&id=3380 (asserting specific reasons that the argument against the CBO's projections being faulty are not warranted).

624 *See* Herszenhorn, *supra* note 618.

reporters at a briefing on January 6, 2011.[625] Democrats said that, if the repeal goes forward, millions of Americans would lose their insurance, millions more would pay more for their health care, and the federal budget deficit would significantly increase.[626] In a letter to Boehner, Democrats also pointed out that repealing the Act would raise prescription drug costs for 3.4 million seniors who fell into the doughnut hole in Medicare drug coverage in 2010.[627]

The CBO also said that repealing the law would result in about 32 million fewer nonelderly Americans having health insurance in 2019, leaving a total of about 54 million nonelderly people uninsured.[628]

Does the general public want the law to be repealed? According to one recent comment,

> First, while the public clearly continues to be split on the law, there is no groundswell of support for outright repeal.
>
> . . . .
>
> In the short term, with the main benefits of the legislation not yet implemented, opponents of the law have an opportunity to press their case. However, once its main provisions are in place in 2014, repeal will be viewed as taking away tangible benefits tens of millions of people have and value. There is an old maxim about our political system that benefits, once conferred, cannot be taken away. Unless that fundamental law of American politics has itself been repealed, after 2014, discussion is likely to shift to improving and expanding the benefits and protections the law provides, not repealing them.[629]

The same comment also notes that,

> Potentially more important than the House repeal vote are the efforts expected to target and defund parts of the law or to slow implementation. How successful these efforts will be remains to be determined. Targeted defunding is itself a complex topic involving

---

[625] *Id.*

[626] *See* Letter from Douglas W. Elmendorf to John Boehner, *supra* note 620, at 2, 5 (noting that the House GOP repeal bill would increase deficit $230 Billion over ten years). The letter is not only a response to the repeal, but also is a response to the GOP's analysis of the Affordable Health Care Act itself. *See* BOEHNER ET AL., *supra* note 620, at 2.

[627] *See* Press Release, Senate Democrats, Senate Democrats to Boehner: Don't Repeal "Donut Hole" Fix for Seniors (Jan. 3, 2011), *available at* https://www.democrats.senate.gov/newsroom/record.cfm?id=330148&.

[628] *See* Letter from Douglas W. Elmendorf to John Boehner, *supra* note 624, at 8–9.

[629] Drew Altman, *Repeal*, KAISER FAM. FOUND. (Jan. 18, 2011), http://www.kff.org/pullingittogether/repeal.cfm.

> disentangling the different kinds of funding authority in the law (for example, mandatory appropriations, entitlements, and tax changes written into the statute vs. discretionary funding requiring future congressional action) and an equally complex web of potential legislative strategies. In general, however, defunding through the budget process cannot eliminate the law's main benefits, such as the insurance reforms, Medicaid expansion, and tax credits to help people afford insurance coverage. But, it can reduce the number of staff in federal agencies available to work on implementation. Frequent oversight hearings are also expected in the House and could create a continuing climate of confrontation around the law.[630]

Governors who oppose the law "will have to weigh that opposition against the substantial new federal funding the law will bring to their states in the form of dollars for subsidies for the uninsured, expanded Medicaid coverage, and grant dollars for a variety of new programs."[631] Repealing the law would strip 32 million Americans of coverage, "deregulate the insurance industry, strip insured persons of coverage protections and enhanced benefits, and worsen the projected federal budget deficit – all while the number of people without insurance gallops upward, along with premium prices."[632]

However, supporters of the Act must do a much better job of communicating its benefits and countering the myths propagated by reform's opponents, such as the totally imaginary death panels.[633]

[T]he 2010 election results underscore how much more important 2012 will be to health policy. The Congress elected 2 years from now will be in place when the core provisions of the ACA that expand coverage—including the Medicaid expansion, subsidies for the uninsured, health insurance exchanges, and employer and individual mandates—are scheduled to go into effect.[634]

The Kaiser Family Foundation reported that

> In our December poll, 26% of the public favored full repeal, 25% favored repealing some parts of the law and keeping other parts,

---

630 *Id.*

631 *Id.*

632 Jonathan Oberlander, *Beyond Repeal—The Future of Health Care Reform*, NEW ENG. J. MED. (Dec. 9, 2010), http://www.nejm.org/doi/full/10.1056/NEJMp1012779.

633 *Id.*

634 *Id.*

> 21% favored keeping the law as it is, and 20% favored expanding the law. Another way of looking at it: almost as many people (20%) favor expanding it as favor repealing it entirely (26%). Not surprisingly, 55% of Republicans want to repeal it entirely and 32% of Democrats want to expand it.[635]

XI. CONCLUSION

Although the future of health care reform is uncertain, we can at least make a preliminary assessment. Though far from perfect, the Act includes numerous positive changes that offer a sound basis for future improvements.

The Act does not address cost control in a meaningful way. Many Americans with health insurance will still face substantial medical bills. Compared to the health insurance programs of other industrialized democracies, the law has limited benefits.[636]

The CBO estimates that 32 million Americans will gain coverage through the expansion of Medicaid, subsidies, and insurance exchanges, but an estimated 23 million people will still lack insurance in 2019: undocumented immigrants; Americans who find insurance too expensive, even with subsidies, and do not qualify for Medicaid; and people who choose to pay the penalty.[637] "In any case, the United States, alone among industrialized democracies, will likely continue to have a large uninsured population for years to come."[638]

The consumer protections included in the Act are very important, but will be ineffective unless they are effectively enforced against an insurance industry that is well-funded, has enormous political clout, and will not change voluntarily. The provisions on quality of care may help, but probably less than their supporters contend. Waste is likely to continue to be a major problem. Finally, one must hope that the debate will move on to a more realistic basis.

"The next fiction is the idea that there exists some market-based reform that would operate immaculately free of intrusive government regulation."

> [T]he health reform debate is not about a fictional war between market-based health insurance and government regulation. It is about whether to provide adequate subsidies to cover the

635 Altman, *supra* note 633.
636 *See* Oberlander & Marmor, *supra* note 39.
637 *Id.*
638 *Id.*

> uninsured and whether to begin a process of leveraging change in the delivery and payment systems through which one-sixth of the U.S. economy is devoted to health care. Under this administration's leadership, the last Congress laboriously and narrowly pushed through legislation ending the crippling stasis that virtually all observers of the U.S. health care system deplore. Their handiwork is not perfect, nor can its full effects be anticipated. Further legislation will unquestionably be necessary—to fix provisions that don't work well and to deal with unanticipated consequences of the legislation. Making that legislation work as well as possible now and figuring out what legislation will make it work better in the future should occupy the nation now, rather than a sterile debate based on a false issue and misrepresentation.[639]

XII. POSTSCRIPT

This postscript will discuss briefly developments that have occurred since this article was written.

In February, 2011, a third federal district court held that the individual mandate[640] is constitutional, and dismissed a lawsuit brought by several individual plaintiffs.[641]

In March, 2022, Judge Vinson stayed his decision holding the entire Act unconstitutional.[642] The stay was conditioned on the government filing a notice of appeal within 7 days and seeking expedited review by the 11th Circuit.[643] The notice of appeal was filed on March 8, 2011.[644] Oral argument is scheduled for June 8, 2011.[645] Appeals are also pending in the 4th, 6th and D.C.

---

[639] Aaron, *supra* note 431.

[640] *See supra* Part IV.B.1[b].

[641] Mead v. Holder, No. 10-950 (GK), 2011 U.S. Dist. LEXIS 18592 (D. D.C., Feb 22, 2011). The plaintiffs have appealed to the D.C. Circuit, and filed their opening brief on May 16, 2011, under the name Seven-Sky v Holder. Opening Brief of Plaintiffs-Appellants, Seven-Sky v. Holder, No. 11-5047 (D.C. Cir., May 16, 2011). *See also* Mary Anne Pazanowski, *Health Care Reform: D.C.-Based Plaintiffs Argue for Reversal of Decision Upholding PPACA's Mandate,* 38 BNA PENSION & BENEFITS REP 1000 (2011).

[642] Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., et al, No. 3:10-cv-91-RV/EMT, 2011 U.S. Dist. LEXIS 22464 (N.D. Fla., Jan. 31, 2011); see discussion *supra* Part IV.B.1[b].

[643] *Id.* at *40.

[644] Mary Anne Pazanowski, *Government Appeals Florida Court Ruling Invalidating Federal Health Reform Law*, 38 BNA PENSION & BENEFITS REP 548 (2011).

[645] Mary Anne Pazanowski, *Administration Seeks Reversal of Decision Invalidating PPACA*, Insurance Mandate, 38 BNA PENSION & BENEFITS REP 751 (2011).

Circuits.[646]

On April 25, 2011, the U.S. Supreme Court denied[647] the Commonwealth of Virginia's attempt to bypass Circuit Court review of a district court decision[648] that held the individual mandate unconstitutional but did not invalidate the entire Act.

Two federal district courts have recently dismissed challenges to the constitutionality of the Act, on the basis that the plaintiffs lacked standing.[649] By contrast, another court allowed plaintiffs who currently lack health insurance to challenge the individual mandate, but held that plaintiffs who do have insurance lack standing to do so.[650]

On May 10, 2011, the 4th Circuit heard oral arguments in two cases.[651] Oral argument in the 6th Circuit is scheduled for June, 2011, and on May 12, 2011 the Court asked the parties to brief additional issues.[652]

In a recent interview, Rep. Dave Camp, Chair of the House Ways and Means Committee, said, with respect to Republican attempts to repeal the Act: "Is the repeal dead? I don't think the Senate is going to do it, so I guess yes."[653]

---

[646] *Id.*

[647] Virginia *ex rel.* Cuccinelli v. Sebelius, 179 L. Ed. 2d 952 (2011).

[648] Virginia *ex rel.* Cuccinelli v. Sebelius, 702 F. Supp. 2d 598, 601 (E.D. Va. 2010).

[649] Kinder v Geithner, No. 1:10 CV 101 RWS, 2011 U.S. Dist. LEXIS 45067 (E.D. Mo., Apr. 26, 2011); Purpura v. Sebelius, No. 10-04814, 2011 U.S. Dist. LEXIS 43153 (D. N.J., Apr. 21, 2011).

[650] Calvey v. Obama, No. 5:10-CV-353 (W.D. Okla., Apr. 26, 2011). See also Mary Anne Pazanowski, *Health Care Reform: Uninsured Plaintiffs Can Challenge Key Health Law Provision, Court Rules*, 38 BNA PENSION & BENEFITS REP 912 (2011) (discussing decisions on standing to challenge the Act).

[651] Liberty University Inc. v. Geithner, No. 10-2347 (4th Cir. May 10, 2011); Virginia ex rel. Cuccinelli v. Sebelius, No. 11-1057 (4th Cir., May 10, 2011). *See* Mary Anne Pazanowski, *Health Care Reform: Liberty University, Virginia Take PPACA Cases To Skeptical Fourth Circuit Court of Appeals*, 38 BNA PENSION & BENEFITS REP 953 (2011).

[652] Thomas More Law Ctr. v. Obama, No. 10-2388 (6th Cir.). See also Mary Anne Pazanowski, *Health Care Reform: Sixth Circuit Asks Attorneys to Brief Additional Issues in Challenge to Reform Law*, 38 BNA Pension & Benefits Rep 999 (2011).

[653] Nathaniel Weixel, Medicare: Rep. Camp Wants Democratic Cooperation, Says He Will Not Act on GOP Medicare Plan, 38 BNA PENSION & BENEFITS REP 907 (2011).