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ARTICLE

HEALTH INSURANCE, RISK, AND RESPONSIBILITY
AFTER THE PATIENT PROTECTION AND
AFFORDABLE CARE ACT

TOM BAKER[†]

The Affordable Care Act embodies a new social contract of health care solidarity through private ownership, markets, choice, and individual responsibility, with government as the insurer for the elderly and the poor. The new health care social contract reflects a "fair share" approach to health care financing. This approach largely rejects the actuarial fairness vision of what constitutes a fair share while pointing toward a new responsibility to be as healthy as you can. This new responsibility reflects the influence of health economics and

health ethics. There are challenges to achieving the solidarity through individual responsibility envisioned in the Act—most significantly "risk classification by design" and non-compliance with the mandates—but the Act contains regulatory tools that the states, the new Exchanges, and the Department of Health and Human Services can use to address these challenges. This Article provides a high level overview of the distribution of health insurance risk and responsibility after the Affordable Care Act and describes how the Act reforms the key institutions that perform that distribution: Medicare, Medicaid, the large-group health insurance market, and the individual and small-group health insurance market.

INTRODUCTION

With the passage of the Patient Protection and Affordable Care Act (PPACA)[1] and the Health Care and Education Reconciliation Act

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[1]   Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

of 2010 (HCERA),[2] health insurance in the United States is on track to become a form of social insurance. While all insurance is social—so that "the loss lighteth rather easily upon many than heavily upon few"[3]—to be considered social insurance in the traditional sense, the insurance must be compulsory and easily available, and the price must bear some relation to the ability to pay.[4]

Parts of the U.S. health insurance system already meet those requirements: most significantly Medicare (for the elderly and formerly working disabled); Medicaid (for certain categories of the poor, including all children in low income families); and workers' compensation (for employment-related illness and injury).[5] U.S. income tax and employment law strongly encourage the provision of general health benefits through employment, making employment-based health insurance a de facto obligation for most large employers and many small employers.[6] But the legal choice to offer health insurance remains that of the employer, and individuals' only health insurance obligations are to pay Medicare taxes and to participate in the financing of Medicaid through the payment of their ordinary state and federal taxes. The Affordable Care Act will make large employers' obligations de jure starting in 2014, and it will create a legal obligation to obtain health insurance for employees' entire lifetime, not just for old age or in the event of total disability.

The Affordable Care Act embodies a social contract of health care solidarity through private ownership, markets, choice, and individual responsibility. While some might regard this contract as the unnatural union of opposites—solidarity on the one hand and markets, choice, and individual responsibility on the other—those familiar with insurance history will recognize in the Act an effort to realize the dream of America's early insurance evangelists: a "society united on

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[2] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified in scattered sections of 20, 26, and 42 U.S.C.).

[3] An Act Concerning Matters of Assurances Used Among Merchants, 1601, 43 Eliz., c. 12, pmbl. (Eng.).

[4] *See* I.M. RUBINOW, SOCIAL INSURANCE 3 (1913) ("[S]ocial insurance is the policy of organized society to furnish that protection to one part of the population, which some other part may need less, or, if needing, is able to purchase voluntarily through private insurance.").

[5] *See infra* Part I.

[6] *See* Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, HEALTH AFF., Nov.–Dec. 2006, at 1538, 1538-39 (explaining that "[t]he exemption of employer payments for health insurance from employees' taxable income, combined with substantial efficiency advantages of group over individual insurance" has led to the prominence of employment-based insurance).

the basis of mutual insurance."[7] Public ownership and pure, tax-based financing are technically easier and almost certainly cheaper routes to health care solidarity, but they come at a cost to the status quo that Congress was not prepared to pay.

This Article explores the contours of the solidarity and individual responsibility embodied in the Act. Part I explains the four main health care financing and risk distribution institutions reflected in the Act—Medicare, Medicaid, the individual and small employer market, and the large-group market—with an emphasis on how the Act changes those institutions and how they are financed. Part II focuses on the distribution of risk and responsibility within and among those institutions. I will argue, first, that the new health care social contract extends the fair-share approach to health care financing while reject-ing the actuarial-fairness vision of what constitutes a fair share and, second, that the Act points toward the recognition of a new responsi-bility to be as healthy as you can. This responsibility reflects the influ-ence of health economics and health ethics, and it is part of the em-brace of risk first described in the insurance-as-governance literature.[8] Part III identifies challenges to achieving solidarity through individual re-sponsibility envisioned in the Act—most significantly what I will call "risk classification by design." Part III also explores the regulatory tools the Acts puts into the hands of the states, the exchanges, and the Department of Health and Human Services (HHS) in order to address these challenges.

I. DISTRIBUTING HEALTH CARE RISK:
THE FOUR-LEGGED STOOL

Since the 1970s, the United States has had three relatively well functioning health care risk distribution mechanisms and one poorly functioning one. The three better-functioning mechanisms are Medi-care, Medicaid, and the large-group market. (All three have long-term cost problems, but this is an issue that the Affordable Care Act does not address.) The poorly functioning mechanism is the individ-ual and small-group market. We can think of U.S. health care risk dis-tribution as a wobbly stool. Some people spill things while sitting on it. Others fall off.

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[7] D.R. Jacques, *Society on the Basis of Mutual Life Insurance*, 16 MERCHANTS' MAG. & COM. REV. 152, 158 (1847).

[8] *See generally* Tom Baker & Jonathan Simon, *Embracing Risk* (reviewing the line of scholarship that "proceed[s] from an implicit belief that risk is a positive force that can be directed toward socially useful ends"), *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 1, 20 (Tom Baker & Jonathan Simon eds., 2002).

Consistent with this metaphor, the Affordable Care Act makes only incremental changes to Medicare, Medicaid, and the large-group insurance market (though the Medicaid change is historic in terms of U.S. social welfare policy). The Affordable Care Act dramatically reforms the individual and small-group insurance market with the aspiration of stabilizing the four-legged stool. Understanding these changes is a necessary first step to understanding the new health care social contract. I will begin with Medicare and Medicaid, which are the easy parts to explain at the general level. I will then turn to the individual and small-group market, and I finish with the large-group market.

A. *Medicare*

The Affordable Care Act made no fundamental changes to Medicare, which is the health insurance component of the Social Security program. Accordingly, health insurance for the eligible disabled (those who paid, or were dependents of someone who paid, Social Security taxes for forty quarters before becoming totally disabled) and seniors (who paid, or were married to someone who paid, Social Security taxes for forty quarters) will continue to consist of four parts:

- Part A, which covers inpatient care, hospice care, and some home health services[9] and is financed entirely by a flat percentage tax on wages paid over the lifetime;[10]
- Part B, which covers other medically necessary or preventive services[11] and is funded in part by a flat percentage tax on wages paid over the lifetime (73%) and in part by premiums paid when enrolled (25%), that are based in part on income and are otherwise uniform regardless of age, health status, or any other factors;[12]
- Part C, Medicare Advantage, which is a private-sector alternative to Parts A and B that allows individuals to obtain their health care benefits, typically including prescription drug benefits, from the health care financing companies

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[9] *Medicare Part A (Hospital Insurance)*, MEDICARE.GOV, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-a.aspx (last visited Mar. 15, 2011).

[10] PATRICIA A. DAVIS, CONG. RESEARCH SERV., R41436, MEDICARE FINANCING 2-3 (2011).

[11] *Medicare Part B (Medical Insurance)*, MEDICARE.GOV, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-b.aspx (last visited Mar. 15, 2011).

[12] DAVIS, *supra* note 10, at 2 fig.1, 4.

active in the large-group market explained below[13] and is funded in much the same way as parts A, B, and D;[14] and

- Part D, which covers prescription drugs[15] and is funded by premiums that vary according to the type of plan but are otherwise uniform regardless of age, health status, or any other factors.[16]

The Affordable Care Act changes Medicare financing and risk distribution in three main ways:

- increasing the progressivity of Medicare financing by raising the wage tax on higher-income taxpayers,[17] adding an income-based component to Part D premiums,[18] and freezing the thresholds for income-based increments to Part B premiums;[19]
- changing the cost-sharing formula for Part D so that individuals will gradually pay a smaller percentage of the costs of medication at the point of sale (meaning that a greater percentage of the costs will be paid in the form of Part D premiums);[20] and

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[13] *Medicare Advantage (Part C)*, MEDICARE.GOV, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx (last visited Mar. 15, 2011).

[14] DAVIS, *supra* note 10, at 2.

[15] *What is Part D (Medicare Prescription Drug Coverage)?*, MEDICARE.GOV, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx (last visited Mar. 15, 2011).

[16] DAVIS, *supra* note 10, at 4-5.

[17] The payroll tax on high-income taxpayers will be increased starting in 2013. PPACA § 9015(a)(1)(A), 26 U.S.C.A. § 3101(b)(2) (West Supp. 1A 2010). High-income taxpayers are those whose wages or self-employment income exceeds $200,000 for individuals or $250,000 for married couples filing jointly. *Id.* The payroll tax will increase by 0.5% from 1.45% to 1.95% on wages. *Id.* The increase will be from 2.9% to 3.4% on self-employment income. *Id.* § 9015(b)(1)(A), 26 U.S.C.A. § 1401(b).

[18] Part D premium subsidies for high-income beneficiaries were reduced beginning in 2011. *Id.* sec. 3308(a)(1), § 1860D-13(a)(7), 42 U.S.C.A. § 1395w-113(a)(7) (West Supp. 1B 2010). If the modified adjusted gross income (MAGI) of beneficiaries exceeds $80,000 for individuals and $160,000 for couples, 42 U.S.C. § 1395r(i)(2) (2006), the monthly amount of the premiums shall be increased by the monthly adjustment amount. PPACA sec. 3308(a)(1), § 1860D-13(a)(7), 42 U.S.C.A. § 1395w-113(a)(7). The Commissioner of Social Security is delegated to carry out and disclose necessary income-related increases in the base beneficiary premium. *Id.* sec. 3308(a)(1), § 1860D-13(a)(7)(D), 42 U.S.C.A. § 1395w-113(a)(7)(d).

[19] The Act freezes the threshold for income-related Medicare Part B premiums for 2011 through 2019. *Id.* sec. 3402(4), § 1839(i)(6), 42 U.S.C.A. § 1395r(i)(6).

[20] *See* HCERA sec. 1101, § 1860D-42(c), 42 U.S.C.A. § 1395w-152(c) (providing for rebates of $250 to those who exceeded the Part D initial coverage limit in 2010). In addition, the Act phases down the coinsurance rate to 25% by 2020:

- reducing federal payments to Medicare Advantage plans,[21] providing bonuses for quality ratings,[22] and obligating these plans to maintain a medical-loss ratio of at least 85%.[23]

In addition, the Act expands coverage for preventive health services and eliminates cost sharing for services designated as cost effective by the U.S. Preventive Services Task Force.[24]   As I will explain in Part II, this new coverage, if extended along the lines of the parallel aspects of the insurance market reforms in the Act, has the potential to represent a significant change in Medicare's distribution of risk and responsibility.[25]

- For brand-name drugs, the Act mandates a Medicare gap coverage discount program by no later than January 1, 2011, HCERA sec. 1101(b)(2), § 1860D-14A(a), 42 U.S.C.A § 1395w-102(a), which requires manufacturers to provide a 50% discount on the negotiated price, PPACA sec. 3301(b), § 1860D-14A(g)(4)(A), 42 U.S.C.A. § 1395w-102(g)(4)(A). This is in addition to federal subsidies providing 25% of the cost by 2020.   HCERA sec. 1101(b)(3)(C), § 1860D-2(b)(2)(D)(ii), 42 U.S.C.A. § 1395w-102(b)(2)(D)(ii).
- For generic drugs, the Act provides federal subsides of 75% of the cost by 2020. HCERA sec. 1101, § 1860D-2(b)(2)(C)(ii), 42 U.S.C.A. § 1395w-102(b)(2)(C)(ii).
- The Act provides a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010. HCERA sec. 1101(a)(1), § 1860D-42(c)(1), 42 U.S.C.A. § 1395w-152(c)(1).

[21] According to the Medicare Payment Advisory Committee, private Medicare Advantage (MA) plans on average are paid an estimated 13% more per beneficiary than what is paid per beneficiary in traditional Medicare plans. *Efforts to Reduce Payments to Medicare Advantage Plans Expected from Obama Administration, Congress*, MED. NEWS TODAY (Nov. 26, 2008), http://www.medicalnewstoday.com/articles/130859.php.   To deal with the problem of overpayment, the Act calls for substantial changes to the calculation formula. All counties or similar jurisdictions are ranked in order of their average fee-for-service (FFS) spending, regardless of their territory or population. HCRA sec. 1102(b), § 1853(n)(1)–(2), 42 U.S.C.A § 1395w-23(n)(1)–(2). The federal payments (MA benchmarks) will be an applicable percentage of a county's average FFS spending, with higher payments (the MA benchmark as 115% of FFS rates) for areas with low FFS spending and lower payments (the MA benchmark as 95% of FFS rates) for areas with high FFS spending. *Id.* sec. 1102(b), § 1853(n)(2)(B), 42 U.S.C.A § 1395w-23(n)(2)(B). The new formula will be phased in during the next two to six years and will be fully phased in by 2017. *Id.* sec. 1102(b), § 1853(n)(3), 42 U.S.C.A. § 1395w-23(n)(3).

[22] Beginning in 2010, the MA benchmarks will be increased if the plans receive four or more stars, based on the current five-star quality rating system; qualifying plans in qualifying areas receive double bonuses. *Id.* § 1102(c), § 1853(o), 42 U.S.C.A. § 1395w-23(o).

[23] *Id.* sec. 1103, § 1857(e)(4), 42 U.S.C.A. § 1395w-27(e)(4). Beginning in 2014, MA plans that fail to have the minimum medical-loss ratio shall remit partial payments to the Secretary of HHS. *Id.* The Secretary shall suspend plan enrollment for two years if the medical-loss ratio is less than 85% for three consecutive years and terminate the plan contract if the medical-loss ratio is less than 85% for five consecutive years. *Id.*

[24] PPACA sec. 4003(a), § 915, 42 U.S.C.A. § 299b-4 (West Supp. 1A 2010).

[25] PPACA increases Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates, including preventive services "recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual."   PPACA secs. 4104, 10406,

B. *Medicaid*

In form, the Act changed Medicaid only incrementally, but these changes are very significant in historical terms. The Act, for the first time in U.S. history, explicitly recognizes a national entitlement to health care for all of the poor—including able-bodied, working-age individuals—to be financed through general tax revenues. The Affordable Care Act thus abandons the concept of the deserving poor that has long been one of the main features of U.S. social welfare policy, including policies on access to health care.[26] Starting in 2014 all lawful U.S. residents with family incomes of less than 133% of the federal poverty level (FPL) will be entitled to Medicaid.[27] Before the Act, Medicaid was available on a national basis only to pregnant women, children, parents of dependent children, and the elderly and disabled. These individuals had to meet state-determined income ceilings that varied by category, though there was a national floor for some categories: 100% of the index for the elderly, disabled, and children aged 7 to 19, and 133% of the index for pregnant women and children 6 years of age or younger.

After the Act, states remain free to expand Medicaid coverage beyond the new national floor; thus, categorical differences may persist at the state level.[28] But the new incentive for states to establish "basic health programs" for individuals with incomes in the range of 133%–200% of the poverty index,[29] together with the economies of scale potentially available from combining these basic programs with Medicaid, creates the possibility for a nearly uniform national entitlement to free health care for individuals in families with incomes up to 200% of the poverty index. Almost all of the new Medicaid costs will be borne by the federal government and paid for out of general reve-

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§ 1833(a)(1)(T), 42 U.S.C.A. § 1395*l*(a)(1)(T) (West Supp. 1B 2010). In addition, the Act provides coverage for an "annual wellness visit." *Id.* sec. 4103(a), § 1861(s)(2)(FF), 42 U.S.C.A. § 1395x(s)(2)(FF). The United States Preventive Services Task Force was created by PPACA sec. 4003(a), § 915(a), 42 U.S.C.A § 299b-4(a).

[26] *See generally* FRANCES FOX PIVEN & RICHARD A. CLOWARD, REGULATING THE POOR: THE FUNCTIONS OF PUBLIC WELFARE 343-406 (updated ed. 1993) (emphasizing the longstanding practice in the United States of enforcing the idea of work when providing public relief to the poor).

[27] PPACA sec. 2001(a)(1)(C), § 1902(a)(10)(A)(i)(VIII), 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII).

[28] *See id.* sec. 2001(e)(1)(A)–(B), § 1902(a)(10)(A)(ii), (hh)(1), 42 U.S.C.A. § 1396a(a)(10)(A)(ii), (hh)(1) (allowing states to extend coverage to individuals "whose income . . . exceeds 133 percent of the poverty line").

[29] *Id.* § 1331(a)(1), (e)(1)(B), 42 U.S.C.A. § 18051(a)(1), (e)(1)(B).

nues.[30] States that had previously expanded coverage to individuals who are newly eligible nationally will receive federal funds on a phased-in basis so that they will receive the same percentage of assistance as other states by 2019.[31]

C. *The Individual and Small-Group Market*

The Affordable Care Act makes the most dramatic changes to the individual and small-group insurance market, aiming to create:

- a single health insurance pool in each state;[32]
- populated by all lawful residents in the state who do not have health benefits through a government program or a large employer;[33]
- serviced by health insurance plans that provide all essential health care benefits and compete on the basis of cost and quality;[34] with
- guaranteed access and identical premiums for all, subject to a few narrowly tailored exceptions that do not include health status.[35]

The practical challenges to achieving this goal are addressed in Part III. Here I explain only how the market is supposed to work, in order to identify the explicit choices about the distribution of health care risk and responsibility embodied in the Act.

For present purposes, the key elements of the individual and small-group market reforms are the following:

- the mandates
- the subsidy
- minimum coverage requirements
- open enrollment and guaranteed renewal

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[30] *See* HCERA sec. 1201(1)(B), § 1905(y)(1), 42 U.S.C.A. § 1396d(y)(1) (setting the amount of federal matching funds provided to states for newly eligible individuals at 100% from 2014 through 2016 and decreasing assistance only slightly to 90% by 2020).

[31] PPACA sec. 1201(2)(b), § 1905(z)(2), 42 U.S.C.A. § 1396d(z)(2).

[32] *Id.* § 1312(c), 42 U.S.C.A. § 18032(c). Initially, the Act creates two separate pools in each state—the individual pool and the small group pool—but states are permitted to combine the pools, a result that is most consistent with the solidarity objectives of the Act and that, I predict, will be administratively easier and less costly in the long run. *Id.* § 1312(c)(3), 42 U.S.C.A. § 18032(c)(3). This is the reason that I treat the individual and small-group market as a single leg of my metaphorical four-legged stool.

[33] *Id.* § 1312(c), 42 U.S.C.A. § 18032(c).

[34] *Id.* § 1302, 42 U.S.C.A. § 18022.

[35] *Id.* sec. 1201(4), § 2701(a), 42 U.S.C.A. § 300gg(a) (West Supp. 1A 2010).

- limits on individual risk-based pricing
- risk adjustments
- health exchanges

The paragraphs that follow briefly explain each of these elements in order to set the stage for the risk and responsibility analysis.

The Mandates. The Act obligates all lawful citizens to obtain "minimum essential coverage"[36] and all large employers—i.e. those with more than 100 employees—to start providing minimum essential coverage to their employees in 2014.[37] The structure of these mandates makes obtaining coverage through the individual and small-group market the residual health care financing mechanism for people who do not qualify for a government health benefit program (Medicare, Medicaid, and Veterans benefits) or work for a large employer. The individual mandate is an important part of the solidarity equation because it requires everyone to be in the health insurance risk pool, addressing the adverse selection problem that would follow from other provisions of the Act that make it possible for high-risk people to enter the health insurance pool.[38]

The Subsidies. The individual mandate obligates individuals to obtain a health plan. The subsidies encourage them to purchase a plan and reduce the likelihood that they will qualify for the hardship exceptions.[39] Beginning in 2014, people with incomes up to 400% of the FPL will be eligible for financial assistance for coverage through the state health insurance exchanges: Those with incomes under 133% of the FPL will be covered under the newly expanded Medicaid program.[40] Those with incomes up to 400% of the FPL will qualify for tax credits to reduce their premiums.[41] They will also qualify for limited cost sharing under their plans to enable them to pay less out of pock-

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[36] *Id.* § 1501(b), 26 U.S.C.A. § 5000A(a).

[37] *See id.* § 1304(b)(1), 42 U.S.C.A. § 18024(b)(1) (West Supp. 1B 2010) (defining "large employer" under the Act to be those with "at least 101 employees"); *id.* § 1513(a), 26 U.S.C.A. § 4980H(a)(1) (West Supp. 1A 2010) (penalizing "large employers" who do not provide "minimum essential coverage"). The fact that the "minimum essential coverage" definition for large employers is almost content free is a challenge to the solidarity goal that I will address in Part III.

[38] *See infra* Section III.A.

[39] *See* HCERA § 1002(b)(2), PPACA § 1501(b), 26 U.S.C.A. § 5000A(e) (exempting from the mandate certain individuals who cannot afford coverage).

[40] PPACA sec. 2001(a)(1)(C), § 1902(a)(10)(A)(i)(VIII), 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII) (West Supp. 1B 2010).

[41] HCERA § 1001(a)(1), 26 U.S.C.A. § 36B(b)(3)(A)(i) (West Supp. 1A 2010).

et.[42] Both the tax credits and reduction in cost sharing will apply on an income-based sliding scale and similarly will be structured to correspond to the actuarial categories of the plans.[43] General federal revenues will fund the subsidies, which thus represent a major ability-to-pay component of the new health care social contract.

   Minimum Essential Coverage Requirements. The minimum essential coverage requirements set a floor for contract quality standards on the health plans that may be offered in the individual and small-group market beginning in 2014. These standards have three primary components. First, plans must cover "essential health benefits," which are a package of benefits that the HHS Secretary will define.[44] Second, the plan must limit annual cost sharing (e.g., deductibles and co-insurance) to the amount authorized under the Affordable Care Act's Health Savings Accounts (HSAs).[45] In subsequent years, the limitation will be indexed to the annual limit on HSAs for self-only coverage and double that amount for any other plan.[46] Third, the plan must meet one of four "actuarial value" requirements, which vary by level of coverage (bronze, silver, gold and platinum) and which set a percentage ceiling on the aggregate cost sharing of all the individuals in the plan.[47] The "actuarial value" of a plan refers to the percentage of the total costs, to be paid by the plan, of covered services provided to all of the plan's participants, in the aggregate. For example, a silver-level plan must have an actuarial value of at least 70%, meaning that it cannot impose aggregate cost sharing of more than 30% of the total cost of covered benefits on the participants in the plan.[48] In addition, the state-based exchanges may have discretion to include additional requirements based on their authority to determine whether "making available such [a] health plan through such [an] Exchange is in the interests of quali-

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   [42] PPACA § 1402(c)(1)(A), 42 U.S.C.A. § 18071(c)(1)(A) (West Supp. 1B 2010).
   [43] *See* HCERA § 1001(a)(1)(C), (b)(1)(A), PPACA § 1402(c)(1)(B), 42 U.S.C.A. § 18071(c)(1)(B) (coordinating reductions with actuarial value limits).
   [44] *Id.* § 1302(a)–(b), 42 U.S.C.A. § 18022(a)–(b).
   [45] *Id.* § 1302(c)(1)(A), 42 U.S.C.A. § 18022(c)(1)(A).
   [46] *Id.* § 1302(c)(1)(B), 42 U.S.C.A. § 18022(c)(1)(B).
   [47] *Id.* § 1302(a)(3), 42 U.S.C.A. § 18022(a)(3).
   [48] *See id.* § 1302(d)(1)(B), 42 U.S.C.A. § 18022(d)(1)(B) (defining a silver-level plan as one that covers seventy percent of a policyholder's costs or "benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan").

fied individuals and qualified employers in the State or States in which such Exchange operates."[49]

These minimum quality standards are designed to ensure that everyone actually receives adequate health care benefits when they fulfill their responsibility to be insured. In addition, by reducing the range of variation among plans, the minimum standards reduce the room for what I call "risk classification by design"—the creation of separate risk pools as individuals self-select into different health care products according to their self-assessed health risk status, or what economists refer to as "separating equilibria."[50] I will address risk classification by design, which is one of the most important challenges to the solidarity equation, in Part III.

Open Enrollment and Guaranteed Renewal. The open enrollment[51] and guaranteed renewal requirements[52] mean that all health insurance plans in the individual and small-group market must accept everyone who chooses to apply for or renew health insurance. These requirements eliminate the traditional authority of health insurance companies to choose whom they will insure—an authority that insurance companies have had no realistic choice to exercise in any way other than to exclude from the health insurance pool those people who most need to be in the pool.[53] It is important to note that making

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[49] *Id.* § 1311(e)(1)(B), 42 U.S.C.A. § 18031(e)(1)(B). The Act also contains requirements regarding transparency and quality improvement that the exchanges are to enforce. *See, e.g., id* § 1311(e)(2), 42 U.S.C.A. § 18031(e)(2) (requiring the exchanges to collect information about premium increases); *id.* § 1311(g), 42 U.S.C.A. § 18031(g) (requiring periodic reporting to the exchanges of activities by qualified health plans in order to promote health via market-based incentives). States that require plans to provide coverage for health care services that go beyond the essential benefits must pay for the cost of those additional services. *Id.* § 1311(d)(3)(B)(ii), 42 U.S.C.A. § 18031(d)(3)(B)(ii).

[50] As Alma Cohen and Peter Siegelman explain, "Since insurers cannot distinguish between high-risk and low-risk agents, the two groups must be offered the same prices for insurance. Given that the two groups face the same prices, their different risks will lead them to act differently. In particular, high-risk agents can be expected to purchase more insurance." Alma Cohen & Peter Siegelman, *Testing for Adverse Selection in Insurance Markets*, 77 J. RISK & INS. 39, 43 (2010).

[51] *See* PPACA sec. 1201(4), § 2702(a)–(b)(1), 42 U.S.C.A. § 300gg-1(a)–(b)(1) (West Supp. 1A 2010) (requiring that every health insurance issuer accept all applicants, but allowing issuers to limit acceptances to certain "open or special enrollment" periods).

[52] *See id.*, § 2703(a), 42 U.S.C.A. § 300gg-2(a) ("[I]f a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.").

[53] *See* Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 376-78 (2003) (explaining the "competitive power of

it too easy for high-risk individuals to join the insurance pool actually poses a challenge to the solidarity equation by creating the possibility that people will violate the mandate unless and until they really need serious health treatment. This is yet another challenge that I will address in Part III.

Limits on Individual Risk-Based Pricing. In the traditional, actuarial approach to private market insurance, insurance is understood as a series of bilateral contracts between insurance companies and their policyholders, and those contracts are understood as wagers, the odds (and therefore the price) of which should be set according to the likelihood that the policyholder will "win" by making a claim.[54] If people have the choice whether to buy insurance or not, and if insurance companies have the authority to decide on an individual basis how much to charge for their products, then an insurance company that fails to set prices on this basis will not last long. The result is that those people who most need to be in the pool cannot afford to join the pool because their premiums will be too high.[55] Accordingly, achieving health care solidarity through the private market requires limiting insurers' authority to decide on an individual basis how much to charge for their products.

The Act allows health plans in the individual and small-group market to vary their prices on the basis of only four factors: whether the applicant is an individual or family, the geographic region in which the applicant lives, age, and tobacco use.[56] For the latter two factors, there are limits on the pricing differentials—3 to 1 for age-based pricing differentials and 1.5 to 1 for tobacco-use pricing differentials—meaning that the price for the oldest group in the pool may not be more than three times the price for the youngest group and the price for the heaviest tobacco users may not be more than one-

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risk classification," which "produces a classification 'arms race,' in which insurers either maintain their classification edge or face the loss of low risks to the competition and the migration of the high risks to their insurance rolls"); *see also* Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 298 (1993) (noting the common insurance convention that "people are [considered] uninsurable for life insurance if their mortality is five or more times the standard mortality").

[54] *See* Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility* ("[W]hen it comes to health, disability, property, liability, and term insurance, if your withdrawals equal your deposits, you have, in at least some respects, a very unfortunate life."), *in* EMBRACING RISK, *supra* note 8, at 33, 36.

[55] *See* Stone, *supra* note 53, at 308 ("The logic and methods of actuarial fairness mean denying insurance to those who most need medical care.").

[56] PPACA sec. 1201, § 2701(a)(1)(A), 42 U.S.C.A. § 300gg(a)(1)(A).

and-a-half times the price for comparable non-users.[57] In addition, the
Act permits the sale of special, high-deductible policies to people un-
der the age of thirty, and, presumably, these policies will constitute a
separate risk pool.[58] (Such policies represent an example of risk classi-
fication by design explicitly permitted in the Act.) Finally, the Act au-
thorizes wellness programs for small employer plans that may provide
substantial rebates or other benefits to participants (up to 30% of the
total premium, including the employer share, and potentially increas-
ing to 50% at the discretion of the Secretaries of Labor, Health and
Human Services, or the Treasury).[59] The wellness programs have the po-
tential to lead to de facto differential prices based on participation in the
programs, but the programs may not be "a subterfuge for discriminating
based on a health status factor."[60] From a risk and responsibility perspec-
tive, these pricing factors and the wellness programs are among the most
interesting aspects of the Act, as discussed shortly.

Risk Adjustments. Risk adjustments are financial transfers among
health plans based on the aggregate risk of the individuals who choose
to participate in each plan.[61] Plans that end up with a disproportio-
nately high-risk membership are supposed to receive risk adjustment
payments from plans that end up with a disproportionately low-risk
membership so that the price that individuals pay for their insurance
does not depend on their health risk, whether it is due to risk classifica-
tion by design or to other sorting mechanisms that correlate with risk.[62]

The Exchanges. The exchanges are the marketplace through which
individuals and small groups will purchase health care plans. Among
other responsibilities, the exchanges must ensure that the plans listed

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[57] *Id.*

[58] *See id.* § 1302(e)(2)(A), 42 U.S.C.A. § 18022(e)(2)(A) (West Supp. 1B 2010)
(defining eligibility for certain catastrophic coverage plans as extending to those under
the age of thirty).

[59] *Id.* sec. 1201(4), § 2705(j)(3)(A), 42 U.S.C.A. § 300gg-4(j)(3)(A) (West
Supp. 1A 2010).

[60] *Id.*, § 2705(j)(3)(B), 42 U.S.C.A. § 2705(j)(3)(B) (West Supp. 1B 2010). While
the Act warns against misuse, it does not establish criteria for how states should eva-
luate when wellness programs amount to "subterfuge." *Id.*

[61] *See id.* § 1343(a), 42 U.S.C.A. § 18063(a) (creating a state-based risk adjustment
mechanism for plans in the individual and small-group market). For a recent empirical
study of the importance of risk adjustment to redressing classification by design, see Ka-
ren Eggleston & Anupa Bir, *Measuring Selection Incentives in Managed Care: Evidence from
the Massachusetts State Employee Insurance Program*, 76 J. RISK & INS. 159, 171-73 (2009).

[62] PPACA § 1343(a), 42 U.S.C.A. § 18063(a).

on it comply with statutory requirements.[63] The exchanges are also likely to be asked to administer the risk adjustments.[64] Important, unanswered questions about the exchanges include how active exchanges should be in helping consumers make choices and whether states should exercise the option of allowing the federal government to create and operate the exchanges.

In summary, the changes to the individual and small-group market appear to be designed to make that market function as if all of the individuals who bought insurance in each exchange were the members of a very large single employment group with many choices for health benefits, analogous in many ways to the Federal Employee Health Benefit Program (FEHBP).[65] One very important difference is that purchasers of individual coverage on the exchange will pay the full price themselves, using after-tax dollars (subject to the subsidies). As with "cafeteria plans" in the large-group market, there is a potential for risk classification by design. Indeed, because of the very large number of options available on the exchange, some degree of risk classification by design seems inescapable, notwithstanding the risk adjustments and other regulatory tools that I will discuss in Part III.

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[63] *See id.* § 1311(e)(1), 42 U.S.C.A. § 18031(e)(1) ("An Exchange may certify a health plan as a qualified health plan if . . . such plan meets the requirements for certification as promulgated by the Secretary . . . and . . . the Exchange determines that making available such health plan . . . is in the interests of qualified individuals and qualified employers . . . .").

[64] The Act directs the states to administer the risk adjustment process. *Id.* § 1343(a), 42 U.S.C.A. § 18063(a). I predict that the states will assign the task to the exchanges for efficiency reasons, though it is possible that the task will be carried out by the state insurance regulator (though almost certainly in close cooperation with the exchange).

[65] Extensive information about the FEHBP can be found at the website maintained by the U.S. Office of Personnel Management. *Federal Employees Health Benefit Program*, U.S. OFFICE PERSONNEL MGMT., http://www.opm.gov/insure/health/ (last visited Mar. 15, 2011); *see also* Stuart M. Butler & Robert E. Moffit, *The FEHBP as a Model for a New Medicare Program*, HEALTH AFF., Winter 1995, at 47, 48-51 (explaining that FEHBP enrollees "can choose from a variety of health plans, ranging from traditional fee-for-service plans, to insurance plans sponsored by employee organizations or unions, to managed care plan"); Harry P. Cain II, *Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly*, HEALTH AFF., July–Aug. 1999, at 25, 35 (comparing the FEHBP to Medicare and arguing that "the FEHBP has outperformed Medicare every which way—in containment of costs both to consumers and to the government, in benefit and product innovation and modernization, and in customer satisfaction"). *But see* Alain C. Enthoven, *Effective Management of Competition in the FEHBP*, HEALTH AFF., Fall 1989, at 33, 34 (arguing that because of adverse selection problems, in the 1980s some FEHBP "plans . . . gain[ed] or los[t] market share not because they [were] more or less efficient, but because they . . . attracted a less or more costly clientele").

D. *The Large-Group Market*

The Act makes few changes to the large-group market, consistent with the belief that the market has been functioning acceptably well in providing health care access to most people working for large organizations.[66] The large-group market is and will remain lightly regulated by the Department of Labor under the ERISA and HIPAA statutes.[67] The main change introduced by the Act is that large employers—defined as an entity with more than 100 employees—must provide "minimum essential coverage" to their employees starting in 2014.[68]

For large employers that already provide health care benefits (most already do), the new mandate will not impose much in the way of new obligations because—perhaps surprisingly—the Act exempts the large-group market from the "essential health benefits" requirements that will apply in the individual and small-group market.[69] Large-group market plans do, however, have to meet the same annual cost-sharing limits as health plans in the small-group market,[70] meaning that employees' out-of-pocket expenditures for covered health care expenses cannot exceed the maximum amount allowed for Health Savings Accounts[71] and no more than $4000 of this cost sharing may be in the form of a deductible.[72] In addition, large-group market plans will have to comply with some of the Affordable Care Act mandates such as the elimination of annual and aggregate limits on coverage,[73] coverage

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[66] *See* Address Before a Joint Session of the Congress on Health Care Reform, 2009 DAILY COMP. PRES. DOC. 693, at 3 (Sept. 9, 2009) ("[I]f you are among the hundreds of millions of Americans who already have health insurance through your job or Medicare or Medicaid or the VA, nothing in this plan will require you or your employer to change the coverage or the doctor you have."). *But see* Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 146-53 (suggesting that current regulation of the large-group market may fail to prevent employers from engaging in risk classification and "dumping" high-risk employees).

[67] *See* Monahan & Schwarcz, *supra* note 66, at 142-53 (summarizing pre- and post-Affordable Care Act large-group regulation).

[68] *See* sources cited *supra* note 37; *see also* PPACA § 1411(e)(4)(B)(iii), (f)(2)(A), 42 U.S.C.A. § 18081(e)(4)(B)(iii), (f)(2)(A) (outlining procedure for notifying an employer when the employer does not provide minimum essential coverage and may be liable for employees' health care subsidies as well as procedure for appeal of such determinations).

[69] *Id.* sec. 1201(4), § 2707(a), 42 U.S.C.A. § 300gg-6(a) (West Supp. 1A 2010).

[70] *See id.*, § 2707(b), 42 U.S.C.A. § 300gg-6 (subjecting a "group health plan" to the cost-sharing limits set forth in PPACA § 1302(c)).

[71] *Id.* § 1302(c)(1), 42 U.S.C.A. § 18022(c)(1) (West Supp. 1B 2010).

[72] *Id.* § 1302(c)(2)(A)(ii), 42 U.S.C.A. § 18022(c)(2)(A)(ii). For plans that cover a single individual, the limit is $2000. *Id.* § 1302(c)(2)(A)(i), 42 U.S.C.A. § 18022(c)(2)(A)(i).

[73] *Id.* secs. 1001(5), 10101(a), § 2711, 42 U.S.C.A. § 300gg-11 (West Supp. 1A 2010).

for preventive services,[74] dependent coverage,[75] wellness programs,[76] non-discrimination on the basis of health status,[77] and reporting.[78]

The Act also regulates the content of large-group market plans indirectly. If an employer's plans are of such low quality that employees start to buy individual health plans on the exchanges, the employer will be penalized.[79] In addition, states will have the option of giving large employers the choice to include plans offered through the exchanges as part of their employer-sponsored plan, allowing employees to use pretax dollars to buy health plans on the exchange.[80] "Large" employers that are not very large are likely to encourage states to make that option available.

II. DISTRIBUTING RISK AND RESPONSIBILITY AFTER THE AFFORDABLE CARE ACT

After the Affordable Care Act takes full effect, the health care costs of the U.S. population will be distributed as follows.[81]

Most health care costs associated with old age and total disability—apart from long-term care—will be distributed through the Medicare

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[74] *Id.* sec. 1001(5), § 2713, 42 U.S.C.A. § 300gg-13.

[75] HCERA sec. 2301(b), PPACA sec. 1001(5), § 12714, 42 U.S.C.A. § 300gg-14.

[76] PPACA sec. 1204, § 2705(j), 42 U.S.C.A. § 300gg-4(j).

[77] *Id.*, § 2705(a), 42 U.S.C.A. § 300gg-4(a).

[78] *Id.* sec. 1001(5), § 2717, 42 U.S.C.A. § 300gg-17.

[79] HCERA sec. 1003(d), §§ 1513(a), 10106(e), 26 U.S.C.A. § 4980H(b). Amy Monahan and Daniel Schwarcz argue that this penalty may not be enough to induce employers to design plans that will be sufficiently appealing to high-risk workers, raising the possibility that employers will "dump" such workers on to the exchanges. *See* Monahan & Schwarcz, *supra* note 66, at 181-88 (providing a road map for an employer that was considering such an approach). But, read carefully, their article contains a regulatory solution that is within the discretion of the Secretary of Health and Human Services to implement. *Id.* at 189-93.

[80] *See* PPACA § 1312(f)(2)(B), 42 U.S.C.A. § 18032(f)(2)(B) (West Supp. 1B 2010) (allowing such an option starting in 2017).

[81] This discussion focuses on explicit health risk distribution mechanisms, omitting the health care financing provided through government-supported research, health construction and equipment, public health measures, and nonreimbursed state and local hospital expenditures. As calculated by the Office of the Actuary of the U.S. Centers for Medicare and Medicaid Services, expenditures in these omitted categories totaled about 7% of national health expenditures. *See* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2010, at 98 tbl.128 (129th ed. 2009) (reporting $146.2 billion of $2.24 trillion in national health expenditures in 2007). This discussion also omits the health care costs of military families and veterans. These costs are distributed through general federal taxes. In 2007, Defense Department health benefits were $31.7 billion, and Veterans health benefits were $33.8 billion. *Id.*

program, as they are now.[82]   Medicare is available to all lawfully present and working Americans and is financed through a flat-percentage tax on wages paid over an individual's lifetime and through some income-based premiums paid while eligible for Medicare.[83]   Medicare beneficiaries have cost-sharing obligations at the point of service that vary according to the kind of service; the most significant of these obligations are capped at a new, lower level by the Act.[84]

Most health care costs for the lowest income earners will continue to be distributed through the Medicaid program, but Medicaid's deserving poor categories will become less important.[85]   Medicaid is financed through general revenues, principally from the federal government but also from state governments.[86]

Health care cost risks attributable to employment—occupational injury and illness—will be largely distributed through the mandatory, state-based workers' compensation system, as they are now.[87]   Workers' compensation health benefits are entirely paid for by employers through risk-based premiums (or self-insurance arrangements), but this cost is commonly understood to be borne in all or large part by employees in the form of foregone wages.[88]   Assuming the Affordable Care Act

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[82] In 2007, Medicare expenditures were $431.2 billion of the $2.24 trillion in national health expenditures, as calculated by the U.S. Centers for Medicare and Medicaid Services. *Id.*

[83] *See* I.R.C. §§ 3101, 3111 (2006) (setting FICA tax rates for employees and employers respectively); 42 U.S.C. §§ 402, 414(a), 1395c, 1395j, 1395o, 1395r, 1395w-21, 1395w-101 (2006) (setting guidelines for Medicare).

[84] *See* HCERA § 1101, 42 U.S.C.A. § 1395w-102. This discussion does not address Medigap insurance, a form of private insurance regulated by the federal government that provides benefits supplemental to Medicare. *See generally What Are Medigap Basic Benefits?*, MEDICARE.GOV, http://www.medicare.gov/find-a-plan/staticpages/learn/more-about-medigap-basic-benefits.aspx (last visited Mar. 15, 2011) (listing the basic benefits of each Medigap plan).

[85] In 2007, Medicaid and related expenditures were $334.7 billion of the $2.24 trillion in National Health Expenditures as calculated by the U.S. Centers for Medicare and Medicaid Services. *See* U.S. CENSUS BUREAU, *supra* note 81, at 98 tbl.128. Because of the expansion of Medicaid, that number will grow much more rapidly in the short term than will Medicare. It is worth noting that a very large percentage of Americans are at risk of having a low income at some point in their lives. Accordingly, it would be wrong to understand Medicaid as a program that primarily benefits a readily identifiable underclass.

[86] *See* Lawrence D. Brown & Michael S. Sparer, *Poor Program's Progress: The Unanticipated Politics of Medicaid Policy*, HEALTH AFF., Jan.–Feb. 2003, at 31, 33.

[87] 1 ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW § 1.01 (2010).

[88] *See* W. Kip Viscusi & Michael J. Moore, *Workers' Compensation: Wage Effects, Benefit Inadequacies, and the Value of Health Losses*, 69 REV. ECON. & STAT. 249, 249 (1987) (not-

succeeds, workers' compensation health benefits may be merged over time into the general employment-based health benefit system.[89]

Other current health care cost risks of families with one or more members working for large employers will be distributed through the large-group market, as they are now, but without giving employers the choice to opt out.[90] In this market, all of the individual members of a group will pay the same premiums (subject to wellness rebates and risk classification by design), but the prices charged to each group will be based on the projected health care costs of that group; this means that there will be limited risk distribution among groups, especially very large groups.[91] This is the same as at present. Individuals will have cost-sharing obligations at the point of service, which the Act will cap.[92]

The current health care risks of all other individuals lawfully resident[93] in the United States will be distributed through state-based exchanges that attempt to combine all participants into a single risk pool in each state. Premiums will vary according to income, the type of plan selected, the application of the four permitted pricing factors (age, geography, family, and tobacco use), and, potentially, the wellness programs permitted in the small-group market.[94] Individuals will

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ing research showing that "workers are willing to trade off additional wage compensation for higher workers' compensation benefits").

[89] Indeed, allowing employers to satisfy their obligation to provide workers' compensation health benefits by providing general employment-based health benefits could be a state-level incentive that encourages small employers to offer such benefits. Such a measure is likely to be very politically popular in light of (a) the increasing recognition within the business community that workers' compensation has become an expensive form of health insurance and (b) the obvious efficiencies from eliminating the need to determine whether an injury or illness is caused by employment. In 2007, workers' compensation health payments were $32.4 billion of the $2.24 trillion in national health expenditures, as calculated by the U.S. Centers for Medicare and Medicaid Services. U.S. CENSUS BUREAU, *supra* note 81, at 98 tbl.128.

[90] PPACA § 1513(a), 26 U.S.C.A. § 4980H(a)(1) (West Supp. 1A 2010); *see also supra* notes 37, 68 (discussing the requirement that large employers provide "minimum essential coverage").

[91] Monahan & Schwarcz, *supra* note 66, at 151 ("ACA largely excludes employers . . . from . . . risk-sharing arrangements . . . .").

[92] *See* PPACA § 1302(a)(2), (c)(2)(A)(ii), 42 U.S.C.A. § 18022(a)(2), (c)(2)(A)(ii) (West Supp. 1B 2010) (capping annual deductibles for plans not covering single individuals at $4000).

[93] The health care cost risks of individuals who are not lawful residents of the United States will not be distributed through any of these mechanisms. While this is a very important topic, it is part of a larger discussion about the increasingly punitive approach to illegal immigration that is beyond the scope of this Article.

[94] *Id.* sec. 1201(4), § 2704(a), 42 U.S.C.A. 300gg(a) (West Supp. 1A 2010).

have cost-sharing obligations that are capped at the same level as in the large-group market.[95]

Prospectively, these cost spreading institutions distribute the risk of future health care costs among the U.S. population according to the share of applicable premiums and taxes paid by the subpopulations differentially assessed to finance them. With any distribution of risk comes a distribution of responsibility.[96] The distribution of risk embodied in the new health care social contract rests on the following four individual (or family) responsibilities:

- the responsibility to pay taxes, namely (a) the wage taxes that finance Medicare and (b) the general taxes that finance Medicaid, the subsidies offered in the exchanges, and the health care benefits provided to current and former members of the military;
- the responsibility to obtain adequate health care benefits;
- for those who do not obtain health benefits through a government insurance program, the responsibility to pay premiums that reflect the fair share of the total health costs of the relevant health risk pool; and
- the responsibility to be as healthy as you can.

The first two of these are easy to understand and, in light of the preceding descriptions, need little explanation. Nevertheless, it is worth pausing to reflect on the degree to which tax-based financing rests on individual responsibility. The United States has a very high level of tax compliance.[97] This willingness to take responsibility provides reason to believe that Americans will accept their obligation to insure, especially if, as I will argue, the price charged for that insurance reflects widely shared moral values. The other two responsibilities require some more work on my part, because the Act does not explicitly address either "fair share" or "be as healthy as you can." I will begin with fair share.

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[95] *Id.* § 1302(c), 42 U.S.C.A. § 18022(c) (West Supp. 1B 2010).

[96] Baker, *supra* note 54, at 33.

[97] *See* Marjorie E. Kornhauser, *Normative and Cognitive Aspects of Tax Compliance* (noting that even though Americans have traditionally harbored a "strong anti-tax sentiment," tax compliance in the United States is relatively high), *in* 2 TAXPAYER ADVOCATE SERV., INTERNAL REVENUE SERV., NATIONAL TAXPAYER ADVOCATE: 2007 ANNUAL REPORT TO CONGRESS 138, 145-46 (2007).

A. *The Fair Share Approach to Responsibility for the Cost of Health Care*

The Affordable Care Act continues a long-term trend in U.S. health care financing away from the ordinary market approach in which people pay for their own health care services at the point of consumption. Increasingly, Americans have been paying what we might call their fair share of the overall cost of health care, primarily through insurance premiums and taxes, and secondarily through cost sharing at the point of consumption. The Act continues this fair share trend by expanding the private insurance market (through mandates and subsidies), expanding Medicaid, reducing some of the cost sharing in Medicare, and placing new limits on the cost sharing permitted in private health plans.

What constitutes a fair share varies across time, space, and cultural context. In the United States, a fair share will almost certainly remain more closely linked to health care consumption than in cultures with less emphasis on autonomy and choice. But this link is contested and subject to administrative and political judgments that produce different results than would the decentralized health care consumption choices of individuals paying directly for those services.

After the Affordable Care Act, the fair share of health care costs paid by individuals will depend more on their ability to pay than on the amount of health care services consumed, and more on current choices than on inherited or previously determined health risks. The fair share will depend more on the ability to pay than in the past because of the increase in Medicare taxes, the elimination of the deserving poor categories at the national level in Medicaid, and the new subsidies offered through the exchanges. It will depend less on consumption than in the past because of the new limits on cost sharing. It will depend less on inherited or earlier-determined health risks because of the elimination of medical underwriting and the limits on individualized risk-based pricing. Finally, the fair share may depend more on some current choices than in the past, because of the new responsibility to be as healthy as you can, a responsibility I will discuss shortly.

Before moving to that topic, however, it is worth considering how the Affordable Care Act's fair share approach compares to that of the traditional private market insurance arrangements that presently exist in the individual and small-group market.

The guiding principle of private market insurance pricing, outside of the employment benefit context, has traditionally been actuarial

fairness.[98] In insurance economics, insurance pricing is actuarially fair if, and only if, the price charged to each person for the insurance exactly matches the expected value of the insurance to that person, as that value can be known using all of the available information (including private information known only to the person).[99] In practice, the concept of actuarial fairness cannot be this rigorous because of transaction costs and private information.[100] Nevertheless, the application of the concept of actuarial fairness has been almost as committed to individualized risk-based pricing as it is defined to be in theory.[101] The main difference between practice and theory lies in the deference, in practice, to the convenience of insurance institutions, which have the discretion to determine when the investment in making individualized risk assessments begins to exceed the return, and in the legal restrictions on the categories that may be used to make pricing distinctions (e.g., no distinctions may be made on race, religion or national origin).[102]

Many things about actuarial fairness interest law professors and people who are used to thinking about fairness in other ways.[103] For present purposes, the most important thing to note is that, as the name of the concept reflects, actuarial fairness explicitly embodies an

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[98] *See* Stone, *supra* note 53, at 290 ("The private insurance industry, the first line of defense in the U.S. system of mutual aid for sickness, is organized around [the] principle of . . . [a]ctuarial fairness . . . .").

[99] SCOTT E. HARRINGTON & GREGORY R. NIEHAUS, RISK MANAGEMENT AND INSURANCE 135 & n.1 (2d ed. 2004).

[100] *See id.* at 179-88 (noting that the three major factors that limit insurability of risk are "(1) premium loadings, which reflect insurer administrative and capital costs; (2) moral hazard that arises because insurance changes a person's incentive to take precautions; and (3) adverse selection that arises when policyholders are better informed about expected claim costs than insurers").

[101] *See* Stone, *supra* note 53, at 300-08 (explaining how medical underwriting in health insurance reflects these principles in practice).

[102] *See* Baker, *supra* note 53, at 381 (explaining that "[r]ace, religion, and national origin are the most commonly prohibited insurance classifications in the United States, but gender, age, and other, more narrowly defined classifications are also prohibited in some contexts").

[103] *See, e.g.*, Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 520-26 (1983) (discussing the use of actuarial classifications in personal automobile and property insurance); Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. C.R.-C.L. L. REV. 355, 358-59 (1997) (asserting that the strong outcry against actuarial assessments of battered women "taps a deeper intuition about the fairness of health insurance underwriting itself"); Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 LAW & SOC'Y REV. 771, 774 (1988) (arguing that "actuarial practices alter[] the way we understand our status as subjects" and cause people to "be stripped of a certain quality of belongingness to others that has long played a role in our culture").

idea about what is fair.[104]   Accordingly, all health insurance that is priced on an actuarially fair basis reflects a fair share approach to the responsibility to pay for the costs of health care. This explains why I describe the extension of the fair share approach in the Affordable Care Act as the continuation of a very long trend. From the beginning, health insurance pricing in the United States has been based on—contested—ideas about what constitutes the fair share of the health care costs paid for by the insurance pool that can or should be charged as premiums to the pool's participants.[105]   The Affordable Care Act extends the fair share approach to health care financing simply by paying for a greater percentage of health care services through insurance.

Actuarial fairness represents an expert approach to what constitutes a "fair share" according to the actuarial profession, which has a responsibility to protect the financial health of the insurance institutions that employ it.[106]   Actuaries are a powerful, if relatively unknown, profession. Their power derives from their claim to a disinterested, mathematical expertise, a claim that, like the core claims of other professions, the law recognizes through the grant of regulatory authority within their field.[107] No new insurance product or price can be introduced in the United States without an actuarial certification from an actuary that the price to be charged for the product complies with state insurance law, meaning that it is "adequate, not excessive, and not unfairly discriminatory."[108]

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[104]   *See* Stone, *supra* note 53, at 290 (explaining that the concepts of actuarial fairness and solidarity are at odds).

[105]   *See* Baker, *supra* note 53, at 377 (describing insurance entrepreneur D.R. Jacques's utopian vision of insurance, in which there would be a "share and share alike" distribution of premiums); *cf.* Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 291 (1996) ("[O]ur insurance arrangements form a material constitution, one that operates through routine, mundane transactions that nevertheless define the contours of individual and social responsibility.").

[106]   *Cf.* TIMOTHY ALBORN, REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY, 1800–1914, at 5-7 (2009) (describing the rise of the actuarial profession in nineteenth-century Britain).

[107]   *See generally* ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 72 (1970) (observing that "[a] profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work"); CORINNE LATHROP GILB, HIDDEN HIERARCHIES: THE PROFESSIONS AND THE GOVERNMENT 135 (1966) (explaining how professionals take advantage of government regulation to maintain control of their professions).

[108]   GA. CODE ANN. § 33-9-21(b)(1) (Supp. 2008). Georgia requires insurance companies to file their motor vehicle insurance rates with the state's insurance commissioner and places the burden on the insurers in any subsequent hearing to show

The concept of actuarial fairness became legally significant in relation to the "unfairly discriminatory" aspect of state insurance pricing law.[109] Within the framework of actuarial fairness, a price is unfairly discriminatory when two people presenting the same risk are charged different prices for the same product, but not when two people presenting different risks are charged different prices.[110] So, to use an example that received extensive discussion following the Supreme Court's decision in 1978 in *City of Los Angeles Department of Water and Power v. Manhart,*[111] charging men and women different prices for annuities or life insurance is actuarially fair—and therefore not unfairly discriminatory—because men and women have different expected lifespans and expected lifespan is central to the computation of expected risk in relation to life insurance and annuities. In *Manhart,* the Supreme Court held that Title VII of the Civil Rights Act[112] prohibited the use of gender-based pricing for annuities in the employment context, notwithstanding the fact that men and women on average have different expected lifespans, thereby limiting the application of the concept of actuarial fairness in that context.[113]

The Affordable Care Act rejects the concept of actuarial fairness more completely than the Supreme Court did in *Manhart.* This rejection can be seen in the deliberate use of the word "discrimination" in the Act to describe the ordinary, actuarially fair (in the loose, practical sense) risk-based decisions of the private insurance market. The Act prohibits "discriminatory premium rates"[114] and all other "discrimina-

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that their rates are not excessive. *Id.*; *see also* MICH. COMP. LAWS § 500.2403(d) (2002) (applying similar requirements to Michigan's casualty insurance rates).

[109] *See* TOM BAKER, INSURANCE LAW AND POLICY 710-21 (2d ed. 2008) (describing legal grounds for antidiscrimination litigation).

[110] *See* MODEL UNFAIR TRADE PRACTICES ACT § 4(G)(1) (Nat'l Ass'n of Ins. Comm'rs 2008).

[111] 435 U.S. 702 (1978); *see also* Simon, *supra* note 103, at 776-84 (discussing *Manhart* and subsequent analysis by insurance and civil rights scholars).

[112] Civil Rights Act of 1964 § 703(a)(1), 42 U.S.C. § 2000e-2(a)(1) (2006).

[113] *Manhart,* 435 U.S. at 710-11.

[114] PPACA section 1201 sets out this restriction in an amendment to the Public Health Service Act:

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

tion against individual participants and beneficiaries based on health status."[115] "Discriminating" among individuals according to their health status is the fundamental characteristic of the actuarially fair approach to insurance, in which individuals pay according to the expected value that insurance has for them and insurance companies compete by identifying new ways to exclude the highest-risk individuals from their pools.[116] By 2014 such discrimination will be illegal throughout the U.S. health insurance market.

The Affordable Care Act does not reject all aspects of actuarial fairness, however. In addition to permitting some individual variation in prices on the basis of the four permitted pricing factors listed in section 1201 (individual/family, geographic region, age, and tobacco use), the Affordable Care Act retains the link between price and ex-

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> (iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and
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> (B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

PPACA sec. 1201(4), § 2701(a)(1), 42 U.S.C.A. § 300gg-1(a)(1) (West Supp. 1A 2010).

[115] PPACA section 1205 also sets out this restriction in a Public Health Services Act amendment:

> A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:
>
> (1) Health status.
>
> (2) Medical condition (including both physical and mental illnesses).
>
> (3) Claims experience.
>
> (4) Receipt of health care.
>
> (5) Medical history.
>
> (6) Genetic information.
>
> (7) Evidence of insurability (including conditions arising out of acts of domestic violence).
>
> (8) Disability.
>
> (9) Any other health status-related factor determined appropriate by the Secretary.

Id. sec. 1201(4), § 2705(a), 42 U.S.C.A. § 300gg-4(a).

[116] As Deborah Stone writes:

> The logic and methods of actuarial fairness mean denying insurance to those who most need medical care. The principle actually distributes medical care in *inverse* relation to need, and to the large extent that commercial insurers operate on this principle, the American reliance on the private sector as its main provider of health insurance establishes a system that is perfectly and perversely designed to keep sick people away from doctors.

Stone, *supra* note 53, at 308.

pected value.[117]   But the Act shifts the relevant measure of expected value from the individual to the group, in line with the approach that already prevails in the large-group market.   In that market, existing law prohibits differential pricing among members of an employment group.[118]   The Affordable Care Act extends this nondiscrimination approach to the individual and small-group market by treating all people buying insurance through each state-based exchange as a single, very large group, similar to the federal employee health program.[119]   Prices in the individual and small-group markets are to be based on the health care costs of the entire pool of people purchasing through the exchange, subject to differentials based on the four factors and to differences in the actuarial value and other design features of the plans.

To summarize, the Affordable Care Act extends the fair share approach to health care financing by bringing more people under the health insurance umbrella.   At the same time, the Act extends the nondiscrimination vision of what constitutes a fair share from the large-group market into the individual and small-group market.   Vestiges of individualized actuarial fairness will remain.   Some of those vestiges, such as the permitted pricing factors in the individual and small-group market, are explicitly authorized.   Other vestiges, such as risk classification by design, are not authorized and will constitute a continuing challenge to achieving the Affordable Care Act's goals of universal coverage and nondiscrimination.   These challenges are addressed in Part III.

B. *The Responsibility to Be as Healthy as You Can*

The Affordable Care Act guides individuals toward a new responsibility to be as healthy as they can be.   This emerging responsibility under the Act is not explicit, nor is it defined with complete clarity.   The Act promotes this new health responsibility by reducing the cost of being healthy in two main ways: through the elimination of cost sharing for designated preventive services,[120] and by authorizing re-

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[117]   *See supra* text accompanying notes 54-60.

[118]   *See* 29 U.S.C. § 1182(a)(1) (2006) (prohibiting group health plans from establishing rules for eligibility on the basis of such factors as health status, medical condition, claims experience, genetic information, and disability).

[119]   *See supra* note 65 and accompanying text.

[120]   *See, e.g.*, PPACA sec. 1001(5), § 2713, 42 U.S.C.A. § 300gg-13 (requiring private health plans to cover designated preventive services). In addition to the nationally designated preventive services, the Act also permits employers to eliminate or reduce the cost-sharing requirements for other "preventive care related to a health condition"

bates and other rewards for participation in wellness programs.[121] The new preventive services rules extend across all private markets and Medicare. Initially, the wellness programs are only universally authorized for employer health plans, but the Act authorizes the creation of pilot wellness programs in the individual market in up to ten states, starting in 2017.[122] If those are successful, it seems likely that Medicare, and perhaps even Medicaid, will employ similar incentives. This new responsibility is consistent with ideas from health economics and health ethics, and with other developments in social welfare policy, such as the shift to defined contribution pension plans.

For present purposes, the most important wellness provision appears in the antidiscrimination section discussed earlier, which "prohibit[s] discrimination against individual participants and beneficiaries based on health status."[123] This provision authorizes group health plans to adopt wellness programs that provide as much as a 30% rebate of the premiums to participating members (with the possibility of rebates up to 50% in the future).[124] The cap on the allowable rebate is based on the total premium paid for the participating individual, including the portion of the premium paid by the employer.[125] Accordingly, in some cases the rebate could easily exceed the employee's share of the premium.

The location of the wellness program provision in the antidiscrimination section of the Act and the prohibition of wellness programs that are a "subterfuge for discriminating based on a health sta-

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without violating the nondiscrimination provisions of the Act. *See id.* sec. 1201(4), § 2705(j)(2)(C), 42 U.S.C.A. § 300gg-4(j)(2)(C) (authorizing employers to establish "[a] program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits)").

[121] *Id.* The regulations promulgated by the National Association of Insurance Commissioners and approved by HHS under the Act allow insurers to include the rebates and rewards as health care quality expenses for purposes of the new medical-loss ratio. *See* Formula for Calculating an Insurer's Medical Loss Ratio, 75 Fed. Reg. 74,864, 74,927 (Dec. 1, 2010) (to be codified at 45 C.F.R. § 158.221) (indicating that wellness program expenses may qualify as expenses to improve health care quality and that expenses to improve health care quality may be included in the numerator for the computation of the medical-loss ratio).

[122] *See* PPACA sec. 1201(4), § 2705(j), 42 U.S.C.A. § 300gg-4(j) (proposing a system of wellness programs); *id.* § 4201, 42 U.S.C.A. § 300u-13 (authorizing grants for community-based wellness programs).

[123] *Id.* sec. 1201(4), § 2705, 42 U.S.C.A. § 300gg-4.

[124] *See supra* note 59 and accompanying text.

[125] *Id.* sec. 1201(4), § 2705(j)(3)(A), 42 U.S.C.A. § 300gg-4(j)(3)(A).

tus factor"[126] make clear that the responsibility embodied in the Act is not the responsibility for an individual to be healthy, but rather the responsibility to be as healthy *as she can.* Otherwise, the responsibility would conflict with the nondiscrimination principles embodied in the Act. Not everyone has the opportunity to be healthy, but everyone has the opportunity to try to be as healthy as she can.

Consistent with the nondiscrimination approach, the Affordable Care Act distinguishes between wellness programs that offer rewards "based on an individual satisfying a standard that is related to a health status factor"[127] and those that do not offer such rewards.[128] Programs that do not offer such rewards are not regulated, except for the requirement that the programs be "made available to all similarly situated individuals."[129] Wellness programs that are open to everyone and that do not have rewards based on health status do not threaten the nondiscrimination goal to the same extent as programs that offer rewards based on health status.[130]

Wellness programs that offer rewards for satisfying a health standard must be "reasonably designed to promote health or prevent disease,"[131] meaning that the program:

- "has a reasonable chance of improving the health of, or preventing disease in, participating individuals,"
- "is not overly burdensome,"

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[126] *See supra* note 60.

[127] PPACA sec. 1201(4), § 2705(j)(1)(B), 42 U.S.C.A. § 300gg-4(j)(1)(B).

[128] The Act contains a safe harbor provision identifying specific programs that will not be subject to further regulation. Such programs include:
- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).
- A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.
- A program that provides a reward to individuals for attending a periodic health education seminar.

Id., § 2705(j)(2), 42 U.S.C.A. § 300gg-4(j)(2).

[129] *Id.*

[130] My intuition is that the take-up rate for wellness programs will correlate with health status in at least some instances. For example, I predict that the healthy will use free gym membership more, while the less healthy will use rewards for diagnostic testing.

[131] *Id.*, § 2705(j)(3)(B), 42 U.S.C.A. § 300gg-4(j)(3)(B).

- "is not a subterfuge for discriminating based on a health status factor," and
- "is not highly suspect in the method chosen to promote health or prevent disease."[132]

The rewards "shall be made available to all similarly situated individuals" and shall allow for "a reasonable alternative standard (or waiver of the otherwise applicable standard)" for individuals for whom it is "unreasonably difficult due to a medical condition" or "medically inadvisable" to satisfy or attempt to satisfy "the otherwise applicable standard."[133]   Taken together, these requirements authorize rewards based exclusively on current, feasible efforts to maintain or improve health. Rewards based on past efforts or based on current efforts that are not feasible would be reflected in a "health status factor," and discrimination on that basis is prohibited. A rebate for *being* healthy is essentially equivalent to a lower price for being healthy. By contrast, a rebate for *efforts* to maintain or improve health can be made available to everyone, and the efforts of those currently in poor health may be the most valuable to the pool and, thus, most worthy of reward.

Accordingly, the overall spirit of the Act strongly suggests that wellness-program rewards should be commensurate with the burden to the individual (i.e., the effort required to qualify for the reward) and the benefit of that effort to the risk pool (i.e., the future health care costs avoided). In economic terms, calibrating the reward to individual burden and the benefit to the pool aligns the interests of the individual with that of the pool and thereby manages the moral hazard of health insurance.[134] In ethical terms, calibrating the reward to effort comports with widely accepted notions of desert, and calibrating the reward to the benefit to the pool reflects the link between individual responsibility and a greater good.[135] While views on what constitutes the greater good are far from uniform in a pluralist society, there is widespread support for the idea that the growth in health care costs should be checked. The Affordable Care Act strongly reflects economists' understanding of health insurance markets, including the

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[132]   *Id.*

[133]   *Id.*, § 2705(j)(3)(D), 42 U.S.C.A. § 300gg-4(j)(3)(D).

[134]   *Cf.* Mark V. Pauly & Philip J. Held, *Benign Moral Hazard and the Cost-Effectiveness Analysis of Insurance Coverage*, 9 J. HEALTH ECON. 447, 459-60 (1990) (noting the importance of moral hazard in evaluating when insurance coverage should be available).

[135]   *See generally* Harald Schmidt, *Bonuses as Incentives and Rewards for Health Responsibility: A Good Thing?*, 33 J. MED. & PHIL. 198, 212-13 (2008) (discussing how bonuses may be thought of as both working in favor of and counter to health solidarity).

idea that health care costs should be managed to benefit society. In addition, the Act strongly reflects the belief that the distribution of health care costs should not depend on "Brute Luck."[136] These are some of the reasons why I conclude that the burden/benefit approach to wellness rebates and rewards is consistent with the Act.

The responsibility to be as healthy as possible reflects a trend in the approach to insurance, risk, and responsibility that Jonathan Simon and I have called "embracing risk"—an approach that is characterized by "policies that embrace risk as an incentive that can reduce individual claims on collective resources."[137] These policies include the shift from defined-benefit to defined-contribution pensions,[138] the shift to investment-linked life insurance products,[139] the political support for "good driver" discounts in automobile insurance, efforts to "end welfare as we know it,"[140] and the widespread increase of risk bearing in the commercial insurance market through self-insured retentions, retrospective premiums, captive insurance companies, and other alternative risk products.[141] All these policies represent efforts to use risk spreading institutions to encourage individuals to govern their own lives in a socially responsible manner.[142]

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[136] *See* Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1927-42 (2011) (explaining the "Brute-Luck" theory of health insurance, which "stands for the idea that insurance should prioritize coverage of medical expenses for harms that the insured could not reasonably foresee and forestall").

[137] Baker & Simon, *supra* note 8, at 3-4.

[138] *See* EDWARD A. ZELINSKY, THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AMERICA 4 (2007) ("[T]he shift from the defined benefit modality to the defined contribution format has altered in a fundamental manner the way in which Americans experience and think about retirement savings.").

[139] *See* Pat O'Malley, *Imagining Insurance: Risk, Thrift, and Life Insurance in Britain* ("Neoliberals, however, by encouraging insurance policy holders to expose their investments to the speculative hazards of the stock market, effectively restored the old sense of *gaming* to insurance . . . ."), *in* EMBRACING RISK, *supra* note 8, at 97, 112.

[140] *E.g.*, Maurice Isserman, *Michael Harrington: Warrior on Poverty*, N.Y. TIMES, June 21, 2009, at BR19.

[141] *See, e.g.*, HARRINGTON & NIEHAUS, *supra* note 99, at 550-69 (providing an overview of alternatives to traditional insurance contracts for transferring risk).

[142] *Cf.* FRIEDRICH NIETZCHE, ON THE GENEALOGY OF MORALS 45-46 (Douglas Smith trans., Oxford Univ. Press 1996) (1887) (arguing that contract law first required the development of people's ability to keep promises); NIKOLAS ROSE, GOVERNING THE SOUL: THE SHAPING OF THE PRIVATE SELF 10 (1990) (arguing that "[c]ontemporary government . . . operates through the delicate and minute infiltration of the ambitions of regulation into the very interior of our existence and experience as subjects").

III. CHALLENGES TO THE NEW HEALTH CARE SOCIAL CONTRACT

The Affordable Care Act's insurance-market reforms present a host of technical challenges that will keep regulators, lobbyists, and health benefit consultants fully employed over the next few years. The Act delegates many of the key line-drawing decisions to the HHS Secretary, such as the definition of essential health benefits and the final determination of what counts as a medical expense for purposes of the medical-loss ratio requirements. The staffs of HHS, the Treasury, and the Department of Labor have been issuing regulations and requests for comments at a rapid rate, and they have thus far met the extraordinarily short deadlines imposed by the Act.[143]

For their part, the states have to work together through the National Association of Insurance Commissioners to address national issues such as the medical-loss ratio, and they have to create the regulatory framework for the exchanges, find contractors that can assemble the necessary hardware and software, and work with HHS to create a uniform framework for data feeds both to and from the exchanges. Insurance companies and group health plan administrators will have to stay abreast of all these developments and design their systems and services in compliance with them. As important and daunting as these tasks may be, they are the kinds of implementation challenges that would accompany any major reform of a significant market, and thus, they are not challenges to the core values the Affordable Care Act reflects.

Apart from the political backlash, I see just two major challenges to the core values embodied in the insurance market regulation portions of the Act: risk classification by design and noncompliance with the mandates. Risk classification by design would separate people into different risk pools through the design of health plans that appeal differentially to people in ways that correlate with their health status, challenging the core nondiscrimination value embodied in the Act. Noncompliance with mandates would take people out of the health insurance risk pool, thereby threatening the core solidarity value embodied in the Act.

As explained in detail below, the Act contains measures that regulators can use to limit risk classification by design. These measures will not be completely successful, but partial success in this regard is

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[143] *See generally Regulations and Guidance*, CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, http://cciio.cms.gov/resources/regulations/index.html (last visited Mar. 15, 2011) (listing the latest regulations and guidance issued to implement enacted health-insurance legislation).

all that can reasonably be expected, given the continued reliance on private-market insurance. Moreover, the partial "failure" will simply mean that more actuarial fairness survives than the Act's drafters may have intended. Actuarial fairness is a longstanding and well-pedigreed approach with many supporters, not all of whom are insurance industry apparatchiks. The Affordable Care Act represents a compromise between competing values. It should therefore be no surprise—and not of overwhelming concern—that the distribution of the costs of essential health care services will reflect a tension between competing approaches to distributing the costs of health care—in this case non-discrimination and actuarial fairness. The Act directs regulators to contain and limit actuarial fairness in health care financing, not to eliminate it.

Carefully considered, noncompliance with the mandates poses a similar kind of challenge. Because everyone can always choose to sign up for health insurance (at least once a year), and because low-income individuals can always qualify for Medicaid, noncompliance with the mandates does not fundamentally threaten access to health care. Rather, noncompliance poses a challenge to risk sharing, similar to risk classification by design. I predict that this challenge will not prove to be significant. Understanding why requires drilling down to consider how the penalties, subsidies, and projected costs of the plans interact. The bottom line is that the carrots and sticks—the subsidies and the penalties—should be enough in combination to keep most people in the pool, as long as they place some reasonable value on having insurance.

A. *Risk Classification by Design*

"Risk classification by design" is my new term for the economic phenomenon that Joseph Stiglitz explored in his Nobel prize–winning work on markets with asymmetric information. Understanding how risk classification by design could work and what tools the Act contains to address this possibility requires working through some economics that may be tougher going than the more philosophical discussion so far. The point is that, in practice, there will be more actuarial fairness (i.e., more discrimination based on health status) on the exchanges than the Act's drafters may have intended, but much less actuarial fairness than presently results.

In a foundational paper with Michael Rothschild published in the 1970s, Stiglitz developed a model that showed how insurance firms can

use insurance product design to solve the "lemons problem," which Stig-litz's co-prize winner, George Akerlof, had identified in the 1960s.[144]

In brief, a lemons problem results when sellers know the quality of the goods that they are selling but buyers do not. Akerlof developed this economic insight using a mathematical model that involved ask-ing readers to imagine a used-car market composed of two kinds of cars: high-quality cars (I call them "peaches") and low-quality cars (which he referred to as "lemons").[145] As he explained, if buyers do not know whether they are getting a lemon or a peach, they will not pay a peach price.[146] Instead, buyers are willing to pay something akin to the average price.[147] But if the owner of a peachy car can't get a peachy price, he will not be as interested in selling it.[148] We can readi-ly see that the used-car market in this imagined world would contain more lemons than peaches, meaning that the average value of the cars in that market would be less than the midpoint between lemons and peaches. This result would reduce the price that buyers would be will-ing to pay, driving even more peaches out of the market, until the market consists primarily of lemons.

As Akerlof pointed out, an insurance market has some of the same features, considered from the perspective of the insurance company.[149] Some insurance buyers are low-risk "peaches" and other insurance buyers are high-risk "lemons." In many cases the insurance buyers have at least some sense of whether they are lemons or peaches. If the insurance company can tell the difference between lemons and peaches, it will charge the peaches a peach price and the lemons a lemon price consistent with actuarial fairness, and the market will work efficiently (as long as the lemons can afford the lemon price, though Akerlof wisely did not address that problem in his theoretical treatment). If insurance companies are not able to tell the difference between lemons and peaches, however, or if they are prevented from

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[144] *See* Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 629, 629 (1976) (asserting that because of imperfect information and consumer risk preferences a competitive market like the insurance market may have no equilibrium); *see also* George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechan-ism*, 84 Q. J. ECON. 488, 489-96 (1970) (explaining the "lemon problem" in the auto-mobile market).

[145] Akerlof, *supra* note 144, at 489.

[146] *Id.* at 490.

[147] *Id.*

[148] *Id.* at 489.

[149] *Id.* at 492-94.

charging different prices, then they will have to charge all of the buyers the same price. This will be a price that will be higher than at least some of the peachy (low-risk) buyers are willing to pay. So the people who choose to buy insurance will be disproportionately high risk, requiring the insurance company to raise the price, driving more of the low-risk buyers out of the pool, and so on.[150] This is the dynamic that nineteenth-century insurance actuaries first called "adverse selection,"[151] and it has proven to be a very real problem in the individual and small-group health insurance market, particularly when companies are prohibited from charging actuarially fair prices.[152]

Stiglitz—the son of an insurance agent[153]—recognized that insurance markets do not always fall apart in real life, even when buyers have private information about their "peachiness."[154] In his paper with Rothschild, he showed in mathematical terms that insurance products can be designed to appeal differentially to people with different risk characteristics, so that people self-select into separate risk pools in a manner that correlates with their risk status.[155] Subsequent empirical research—most significantly in the context of cafeteria-style health care employment benefit plans—has demonstrated that Stiglitz's theoretical predictions are borne out in practice.[156] High-risk people tend to prefer more complete health insurance coverage, fewer restrictions on their choice of doctors, and other plan features that

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[150] The insurance contract—which is not understandable to most consumers—presents the same informational asymmetry from the buyers' perspective. Regulation of the contents of the insurance contract helps to solve that problem. *See* BAKER, *supra* note 109, at 641-43 (describing the theoretical justifications for insurance regulation, among which information asymmetry plays a significant part).

[151] *See* Baker, *supra* note 53, at 375-76 (describing the tendency for low-risk individuals to drop out of insurance pools). To a very substantial extent, all of the twentieth-century advances in the economics of information represent the formalization of the hard-won practical knowledge the insurance industry gained in the nineteenth century. *See* Baker, *supra* note 105, at 246-64 (describing the development of the idea of moral hazard among nineteenth-century actuaries); *see also* Transcript of Interview by Juan Dubra with Kenneth Arrow at Universidad de Montevideo (March 2005), *available at* http://mpra.ub.uni-muenchen.de/967/ (reporting that Arrow first learned about adverse selection and moral hazard when studying for his actuarial exams in the 1940s).

[152] *See, e.g.*, Anemona Hartocollis, *New York Offers Costly Lessons on Insurance*, N.Y. TIMES, Apr. 18, 2010, at A1 (reporting on the "adverse selection death spiral" in the New York HMO market, which was subject to a state community-rating law).

[153] *Joseph E. Stiglitz—Autobiography*, NOBELPRIZE.ORG, http://nobelprize.org/nobel_prizes/economics/laureates/2001/stiglitz-autobio.html (last visited Mar. 15, 2011).

[154] Rothschild & Stiglitz, *supra* note 144, at 634-38.

[155] *Id.*

[156] For a review of the research, see Cohen & Siegelman, *supra* note 50, at 47-62.

make it easier to consume more health care.[157] As a result, cafeteria-style employment health benefit plans tend to produce some risk separation, especially if the portion of the premiums employees pay reflects the differences in the health care costs among the sub-pools.[158] Insurance economists refer to this dynamic as adverse selection,[159] but adverse selection is such a multifaceted and generalizable phenomenon that I think we need a more specific name for this example. I suggest that we call it "risk classification by design."

The Affordable Care Act contains four main tools to reduce risk classification by design in the individual and small-group market: (1) the minimum coverage requirements, (2) the exchange certification requirement, (3) the medical-loss ratio, and, most obviously, (4) the risk adjustments. The paragraphs that follow explain how each of these tools can be used.

1. The Minimum Coverage Requirements

Minimum coverage requirements have the potential to reduce classification by design in two ways. First, because the "essential health benefits"[160] are likely to include all or most of the health benefits that most people need, there is less room for variation in plans that can be used to segment people into separate risk groups. Second, the minimum coverage requirements make it easier for regulators to compare plans to identify differences that could lead to classification by design. As discussed next, the Act specifically directs the Secretary of Health and Human Services to regulate the exchanges to reduce the likelihood of classification by design, and the exchanges will have broad discretion that could be used to the same end.

2. The Exchange Certification Requirement

In order to be sold through the exchange, a health plan must be certified by the exchange. The Affordable Care Act directs the HHS Secretary to develop regulations governing the certification process.

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[157] *Id.* at 62.

[158] *See id.* (summarizing a study of Harvard's health plan finding that low-risk people left the plan when the annual cost went up by $500). Note that recent research suggests that advantageous selection—i.e. low-risk people preferring the higher-price insurance in some situations—may partially offset some instances of adverse selection. Hanming Fang, Michael P. Keane & Dan Silverman, *Sources of Advantageous Selection: Evidence from the Medigap Insurance Market*, 116 J. POL. ECON. 303, 306-07 (2008).

[159] *See supra* note 53 and accompanying text.

[160] *See supra* note 44 and accompanying text.

Significantly, the Act states that the certification requirements shall include the requirement that a plan "not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in such plans."[161]

The Act also grants the exchanges broad discretion to consider the public interest in deciding whether to certify a plan. The Act states:

> An Exchange may certify a health plan as a qualified health plan if—
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> (A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and
>
> (B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates . . . .[162]

Using the authority granted by this provision, an exchange could refuse to certify a plan on the ground that it could by design lead to risk classification, contrary to "the interests of qualified individuals and qualified employers."[163]

It is almost certainly the case that some plan designs that lead to risk segmentation are nevertheless in the public interest. For example, a plan with a tightly controlled network employing aggressive performance-based payment systems might be comparatively unattractive to a high-income, high-risk population, which leads to some risk classification by design. Nevertheless, I would encourage regulators to allow these plans to offer a lower-cost alternative to people willing to trade some choice and convenience and to place some market pressure on provider prices. As this suggests, there are good reasons to tolerate at least some "disparate impact" risk segmentation, to borrow a term from the civil rights discrimination context. What the Act clearly prohibits is plan design deliberately crafted to appeal to a low-risk population. The certification requirement is one tool that exchanges can use to prevent such deliberate risk segmentation.

3. The Medical-Loss Ratio Requirements

The Affordable Care Act requires all health plans to meet minimum medical-loss ratios, a concept that refers to the ratio of medical

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[161] PPACA § 1311(e)(1), 42 U.S.C.A. § 18031(e)(1) (West Supp. 1B 2010).

[162] *Id.*

[163] *Id.*

expenses paid by a plan to the premiums collected by the plan.[164] A minimum-loss ratio requires a plan to spend at least the designated percentage of its premiums on medical and health care quality expenses. The Act defines the minimum medical-loss ratio for individual and small-group plans to be eighty percent; for large group plans, the minimum-loss ratio is eighty-five percent. Plans that do not meet these requirements will have to refund a portion of the premiums collected in order to come into compliance.[165]

Minimum-loss ratios discourage risk classification by design because the loss ratios limit the return that a firm can earn on classification design. Traditionally, a major goal of risk selection was to increase profits by offering low-risk individuals a lower price than that of less adept competitors, but not so much less that the insurer would disgorge to the low-risk customers all of the medical cost savings of using risk selection to "improve" the insurer's risk pool. In theory and in the long run, competition would prevent insurance firms from earning such excess returns, but economic theory rarely discourages firms from vigorous efforts to earn short-term profits.[166]

The minimum-loss ratio takes away these short-term profits by requiring a successful cream-skimming insurer to return to its policyholders all or most of the benefits of the cream skimming. A simple example illustrates how this would work.

Imagine Akerloff's population of insurance buyers, consisting of low-risk peaches and high-risk lemons. The Affordable Care Act prohibits insurers from charging different prices for peaches and lemons and obligates both peaches and lemons to buy insurance. The goal of the Affordable Care Act is for peaches and lemons to each pay the average price (subject to the permitted pricing variations, all of which are based on easily observable characteristics).

Now imagine that Crafty Insure Co. (Crafty) figures out how to design a health plan that is more appealing to peaches than lemons. Crafty could of course charge a price for the health plan that is precisely fitted to the mix of lemons and peaches expected to buy the

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[164] *See generally* James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, HEALTH AFF., July–Aug. 1997, at 176, 176-77 ("In principle, this statistic measures the fraction of total premium revenue that health plans devote to clinical services, as distinct from administration and profit. In practice, however, purchasers, providers, consumers, investors, and regulators interpret the medical loss ratio . . . as measuring what they most like or dislike about managed care.").

[165] PPACA sec. 10101(c), § 2718(b)(1)(B)(i), 42 U.S.C.A. § 300gg-18(b)(1)(B)(i) (West Supp. 1A 2010).

[166] *See supra* note 53 and accompanying text.

plan, in which case the Crafty plan would be much less expensive than the other health plans because health care peaches are much less expensive to insure than health care lemons. Charging the precisely fitted price would not reward Crafty with much profit in return for all that effort. Moreover, Crafty doesn't need to charge the precisely fitted price in order to get the peaches to sign up, because they prefer the Crafty plan. Thus, Crafty charges a bit less than the competition, gets most of the peaches to sign up for the Crafty plan, and earns truly excellent short-term profits. In the long run and in theory this strategy won't work. But, as Keynes famously observed, in the long run we are all dead.[167]

The medical-loss ratios take the excellent short-term returns almost completely out of this picture. If Crafty's premiums significantly exceed medical expenses, Crafty has to return the excess premiums to the policyholders. Crafty may still want to innovate in order to keep or increase market share, but Crafty's upside is limited, especially in relation to cheap-to-insure customers. Let's do the math: the absolute maximum Crafty can keep from the premiums, after medical expenses, is 17.6% of the total amount spent on medical expenses.[168] That 17.6% has to be used to cover all of Crafty's other expenses—marketing, innovation, administration, and paying for the CEO's jet. Since 17.6% of the medical expenses for a population of mixed peaches and lemons is more than 17.6% of the medical expenses for a population of peaches, there is more money to pay for the CEO's jet.

4. The Risk Adjustments

As explained in Part I, the Affordable Care Act directs the HHS Secretary to create a risk-adjustment procedure for plans offered through an exchange to equalize risk sharing among the participants in the exchange. Plans that are populated by people with lower average levels of health risk are supposed to make payments to plans that are populated by people with higher average levels of health risk. This way, the premiums paid will reflect each individual's fair share of the total exchange pool, rather than the pool of the particular plan. Risk-adjustment technology is still in its infancy and, thus, the ability

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[167] JOHN MAYNARD KEYNES, A TRACT ON MONETARY REFORM 80 (1924).

[168] The permitted 15% of the premiums that is excess to the minimum 85% of premiums that must be spent on medical expenses is 17.6% of the 85%. Think of it this way: $15 is 17.6% of $85.

of HHS to fully achieve the solidarity aims of the statute will depend on advancement in this field.[169]

The existing research suggests that risk adjustments can be less complicated in practice than might first appear.[170] The key realization is that, as long as individuals in the pools have health care records, it is possible to do a rough risk adjustment in advance. Individuals pay an average price (subject to the permitted pricing variations), but the difference between this average price and their individualized risk-based price is either paid to or received from the risk-adjustment mechanism.[171] One interesting corollary to these ex ante risk adjustments is that the nondiscrimination norm of the Affordable Care Act will not eliminate the demand for individualized risk assessment technology. Instead, it will simply shift the application of that technology from individualized pricing to the risk-adjustment process.

B. *Noncompliance with the Mandates*

Of all the features of the Act, the individual mandate has received the greatest attention in the post-enactment political debate. There are two main critiques: (1) the mandate is unconstitutional; and (2) the penalties for violating the mandate are underpowered. I will address only the latter here. In summary, I have two responses. First, the penalties are better powered than commonly believed, especially when understood in context. Second, there is reason to believe that the exchanges can succeed even with substantial noncompliance. To the extent that the noncompliant are lower risk, there will be less risk spreading through the exchanges, but this obstacle will principally affect the cost of health insurance for people who are better able to pay for it.

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[169] *See generally* Richard T. Meenan et al., *Using Risk-Adjustment Models to Identify High-Cost Risks*, 41 MED. CARE 1301, 1308-11 (2003) (concluding that risk models can anticipate which enrollees are likely to be high-cost); Wynand P.M.M. Van de Ven & Randall P. Ellis, *Risk Adjustment in Competitive Health Plan Markets* (examining risk-adjustment models in detail), *in* 1 HANDBOOK OF HEALTH ECONOMICS 755, 779-815 (A.J. Culyer & J.P. Newhouse eds., 2000); Florian Heiss et al., *Regulation of Private Health Insurance Markets: Lessons from Enrollment, Plan Type Choice, and Adverse Selection in Medicare Part D* 23-26 (Nat'l Bureau of Econ. Research, Working Paper No. 15392, 2009) (assessing the quality of risk adjustment mechanisms in Medicare Part D).

[170] *See* Meenan et al., *supra* note 169, at 1308 (showing "that even modest improvements in the prediction performance, e.g., sensitivity, of prospective risk models can identify meaningful numbers of patients who are likely to use significant future resources and who represent opportunities for case and disease management").

[171] *Id.* at 1310-11.

1. The Penalties Are Better Powered Than
Many People Realize

To predict the impact of the penalties on compliance rates, it is necessary to focus on more than just the size of the penalty in relation to the price of health insurance. I think the most important thing to focus on is the longstanding cultural commitment in the United States to legal obligations that are understood to be legitimate. Nevertheless, because it is hard to quantify that commitment and because the constitutional challenge to the mandate and the other aspects of the political backlash may delegitimize the mandate, I will set that commitment aside and consider only immediate self-interest.

Consider the situation of a rational, self-employed individual thinking about whether to purchase insurance on the exchange. There are four financial pieces to consider in evaluating how she would make a rational choice about whether to comply with the mandate by buying insurance through the individual exchange: (1) the list price of health insurance on the exchange, (2) the amount of subsidies available to her for that insurance, (3) the penalty for noncompliance, and (4) the value of the insurance to her.

Too much of the discussion about compliance focuses only on the relationship between the list price for insurance and the penalty, without considering either the subsidy or the fact that people are willing to pay something for health insurance. In rational choice terms, the relevant relationship is between the *net price* that people face for insurance on the exchange and the *amount* that they are willing to pay for that insurance.

In that context, the proper way to conceptualize compliance is to think about the penalty as a kind of subsidy. The presence of a penalty for not buying insurance reduces the net price of insurance. The net price is the list price minus the subsidy *and* the penalty that people who comply with the mandate will not have to pay. Please stop to think about this for a moment, because the rest of my explanation depends on this point. Put another way, if you have to pay a penalty for not having insurance, then the net price for buying insurance should reflect the fact that you don't have to pay that penalty. This is just simple arithmetic, but it has not been adequately appreciated.

The net price for each individual will vary, depending on the plan selected, the application of the four permitted pricing factors, the subsidy available, and the exact penalty avoided. Nevertheless, there are a few things that can be said in general about the net price for an individual subject to the mandate. First, the penalty does appear to be

administratively enforceable, albeit not perfectly so. Provided that an individual properly files a tax return (which the vast majority of Americans do[172]), the Internal Revenue Service will know who is uninsured and will assess the penalty. While the statute prohibits the IRS from using its most extreme enforcement measures (criminal prosecutions and liens),[173] the IRS Commissioner has stated that the IRS may withhold refunds and that it will have other ways to collect the penalty.[174]

Second, the maximum net price for the plan on the exchange will be about 6% of an individual's income, which is less than an employee's share of the Social Security tax (which appears as the FICA tax in the information supplied to an employee with her paycheck), currently set at 6.2% of income up to $106,800 in 2010,[175] and less than the 8.6% average of gross income paid for health benefits in the employment context.[176] The 8.6% average means that many employees, especially lower income employees, are paying a much higher percentage, mostly in the form of foregone wages.

Here is how I arrived at the six-percent-of-income maximum net price. No one is subject to the mandate unless her "required contribution" for purchasing health insurance is more than 8% of income (the "required contribution" is the premium for the lowest-priced

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[172] *See* Timothy Noah, *Maybe the Individual Mandate Is Enforceable: The IRS Commissioner Explains How He'll Make You Buy Health Insurance*, SLATE (Apr. 7, 2010, 6:14 PM), http://www.slate.com/id/2250098 (quoting IRS Commissioner Douglas Shulman as saying that "the vast majority of American people have a healthy respect for the law and want to be compliant with their tax obligations and whatever else the law holds").

[173] *See* PPACA § 1501(b), 26 U.S.C.A. § 5000A(g)(2) (West Supp. 1A 2010) (forbidding "any criminal prosecution or penalty" for failure to "pay any penalty imposed by this section" as well as liens and levies).

[174] Noah, *supra* note 172.

[175] I.R.C. § 3101(a) (2006). The Medicare tax is levied in addition to the Social Security tax. *Id.* § 3101(b). The Social Security's Old-Age, Survivors, and Disability Insurance program sets a "taxable maximum" each year; for 2011, the limit was $106,800. *See Contribution and Benefit Base*, SOCIAL SECURITY ONLINE, http://www.socialsecurity.gov/OACT/COLA/cbb.html (last updated Dec. 29, 2010).

[176] Employee health benefits represented 6.6% of employers total cost of compensation during the last decade. *Wages and Benefits: A Long-Term View*, THE HENRY J. KAISER FAMILY FOUND., fig.3 (Nov. 2009), http://www.kff.org/insurance/snapshot/chcm012808oth.cfm. Employees' share of the cost of health benefits now represents 30% of the total. GARY CLAXTON ET AL., THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 1, *available at* http://ehbs.kff.org/pdf/2010/8085.pdf. This means that people who obtain health insurance through work presently pay, on average, 8.6% of gross income for that insurance. Most of that "payment" is in the form of foregone wages.

bronze plan minus the subsidy available through the exchange).[177]   If the individual is subject to the mandate, the penalty for not buying insurance is the greater of (a) $695 per person in 2016, indexed for inflation thereafter, up to a family maximum of three times the individual rate, with children counted at 50%, so that the maximum penalty is reached with a family of four, or (b) 2.5% of income above the income tax-filing threshold.[178]   Subtracting the 2.5% penalty from the 8% maximum price leads to a net price of 5.5%, which I increased by 0.5% to reflect the fact that the penalty is not assessed on income below the filing threshold to arrive at the figure of about 6% of income as the maximum net price.

Third, because the minimum penalty will be more than 2.5% of net income for many lower-income people, the net price will be a lower percentage of income for many households. The $695 minimum individual penalty is more than the 2.5% penalty for any individual making less than $37,150.[179]   The $2085 minimum penalty for a family of four is more than the 2.5% penalty for any family of four making less than $102,100.[180]   Median U.S. family income in 2008 was $61,521.[181]   Even allowing for inflation in median income between now and 2016, this means that a large percentage of the people re-

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[177]   PPACA §§ 1501(b), 10106(b), 26 U.S.C.A. § 5000A(e)(1) (exempting from the mandate individuals whose "required contribution" exceeds 8% of income and defining "required contribution" to be the price for the lowest priced bronze plan on the exchange, minus the subsidy that the individual would be eligible for through the exchange). It is worth noting that the 8% threshold for the mandate is computed based on the lowest-priced bronze plan while the subsidies are computed based on the second lowest-priced silver plan.

[178]   HCERA § 1002(a)(2)(A), PPACA §§ 10106(b)(3), 1501(b), 26 U.S.C.A. § 5000A(c)(3)(A). In 2016, that threshold will be $9350 for an individual and $18,700 for a married couple filing jointly. The penalty is capped at the price of a bronze plan on the exchange. According to the Congressional Budget Office, an individual bronze plan will probably cost about $4000 in 2016, and a family plan will cost about $12,000. *See* CONG. RESEARCH SERV., R41331, INDIVIDUAL MANDATE AND RELATED INFORMATION REQUIREMENTS UNDER PPACA 8 (2010). An individual reaches the cap at about $169,000 annual income, and a family at about $499,000. Considering that only 5% of U.S. families made more than $199,999 in income in 2008, it seems quite unlikely that the caps will be reached very often. *See* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2011, at 455 tbl.694 (130th ed. 2010), *available at* http://www.census.gov/compendia/statab/cats/income_expenditures_poverty_wealth.html.

[179] $37,150 minus the single taxpayer filing threshold of $9350 equals $27,800. 2.5% of $27,800 is $695.

[180] $102,100 minus the married filing jointly threshold of $18,700 equals $83,400. 2.5% of $83,400 is $2085.

[181]   U.S. CENSUS BUREAU, *supra* note 178, at 455 tbl.695.

quired to purchase insurance on the exchange will face a net price of *less* than 6% of income.

Finally, if many middle-income Americans are unwilling to spend 6% of their family income on health insurance, the U.S. has a health care cost expectations problem that will require much more than a higher-powered penalty to address. Americans who obtain their health insurance through work presently pay, on average, 8.6% of their gross income for that insurance.[182] People cannot reasonably expect to pay less for comparable coverage through the exchange. The Congressional Budget Office reports that most current employment plans are similar to the silver plans that will be offered on the exchange and, thus, more generous than the bronze plans that I have been using for my calculations. Bronze plans are expected to cost about 25% less than silver plans,[183] so the 6% of income *maximum* net price seems more than fair.

2. The Exchanges Can Tolerate Noncompliance

Inevitably, some people will not participate in the exchange even though they are supposed to. Economic theory suggests that, on average, the people who do not participate will be healthier than those who do.[184] Some research suggests that the extent of this adverse selection will be less than theory predicts.[185] Nevertheless, for present purposes, I will assume the theoretical prediction to be borne out in practice. Will that make the exchanges unsustainable? This is a complicated question that requires empirical estimations to be answered with precision, but it can be thought through in a rough way as follows.

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[182] *See supra* note 176.

[183] The Congressional Budget Office (CBO) reports:

CBO estimates that premiums for Bronze plans purchased individually in 2016 would probably average between $4,500 and $5,000 for single policies and between $12,000 and $12,500 for family policies. For comparison, the previous analysis of the PPACA as introduced found that average premiums among all types of plans in 2016 would be about $5,800 for single policies and about $15,200 for family policies. Average premiums for Bronze plans would be lower than average premiums for all plans because the actuarial value of Bronze plans would be 60 percent, compared with an estimated average actuarial value for all individually purchased plans of roughly 72 percent.

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

[184] Cohen & Siegelman, *supra* note 50, at 43.

[185] *See id.* at 41 (explaining that adverse selection is not present in all mandates).

First, raising the average risk level of people on the exchange will not raise the maximum net price that any individual would be required to pay in order to avoid the penalty. Nor will it raise the maximum net price that anyone with a family income of less than 400% of the federal poverty level will have to pay in order to actually purchase health insurance on the exchange.[186] Those maximums are set by statute, not by the market, and they are designed so that most people buying insurance on the exchange will not be paying the market price. Raising the average risk level increases the market price, not those statutory ceilings. Thus, the net price for most people will not change.

Second, as a corollary to the first point, raising the average risk level would increase the net price only for higher-income households that are not eligible for the subsidies. By definition, those households are better able to afford a higher price. Significantly, those same households are less likely to buy insurance through the individual exchange, however, because they receive the most benefit from obtaining their health insurance through their employers—in other words, to get their health insurance subsidy, higher-income people need to "buy" their insurance through work in the form of foregone wages. The higher the price they face on the individual exchange, the more valuable their tax subsidy will be and, therefore, the more likely they are to push to receive their health benefits through employment. In states that integrate the individual and small-group exchanges, those individuals may obtain their insurance through the exchange in either event. But, if only because of the difficulty of amending an employee benefit plan to eliminate health benefits, someone participating in the exchange through employment is less likely to drop out of the exchange when the price goes up.

Third, even if noncompliance does raise the average risk level of people buying on the exchanges, that result may not increase the cost of the subsidies to the federal government. The likelihood of this event depends on the relationship between the penalties that the federal government collects, the subsidies that it would have paid to those who chose not to participate, and the additional subsidies it pays as a result of the increased average risk level of those people purchasing on the exchange.[187] As long as the federal government is able to pay

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[186] *See supra* note 40 and accompanying text.

[187] The underlying intuition can be seen by thinking about the following (obviously not serious) suggestion: if the federal government really wants to save money under the Affordable Care Act, it should pay low-income people to flout the mandate, and it should pay low-income, high-risk people serious money to relocate permanently to Mexico.

the increase (if there is any) in subsidies, the sustainability of the exchanges will not be affected.

Obviously, this mental exercise does not prove that the exchanges can tolerate significant noncompliance. Combined with the preceding discussion of the penalties, however, I see cause for optimism, while recognizing the need for a more systematic empirical estimation of the impact of noncompliance on the exchanges.

CONCLUSION: THE MORAL OPPORTUNITY OF INSURANCE

Political scientist Deborah Stone has long argued that insurance should be understood in political terms and not simply as an institution that modifies individual incentives.[188] As she explains, bringing a sphere of human activity into the insurance field necessarily begins (or continues) the moral and political conversation:

> Political science offers a very different interpretation of the steady, long-term growth of insurance in modern industrial societies. Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation. Insurance influences how individuals behave, not so much by dangling incentives in front of them one by one, but rather by offering arenas for collective moral deliberation and political action.[189]

In the case of health care, the moral and political conversation about risk and responsibility is long underway. The Affordable Care Act reflects and contributes to that conversation, but it makes no radical changes. The concept of the deserving poor disappeared from national Medicaid standards, but that was an incremental step and hard to avoid under any approach to universal coverage. Ability to pay will matter now somewhat more than in the past, but how could it not in the face of rising health care costs and following a period of such increase in financial inequality? The individual and small-group market will be remade, but not out of whole cloth. Signs point toward a new responsibility for individuals to be as healthy as they can, but those signs appear alongside many others enlisting individual responsibility in support of a greater good. What that greater good is—or should

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[188] Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity* ("[T]hrough its effects on political culture and collective political action, insurance increases the number and kinds of events that we consider adverse and worthy of collective responsibility."), *in* EMBRACING RISK, *supra* note 8, at 52, 52.

[189] *Id.* at 74.

be—will remain a matter of debate. As I hope this Article has demon-
strated, health insurance will be one important arena in which that
debate will take place.