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Theodore Ruger

University of Pennsylvania Carey Law School

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Repository Citation

Ruger, Theodore, "A New Deal in a World of Old Ones" (2011). *Faculty Scholarship at Penn Law*. 667.
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A NEW DEAL IN A WORLD OF OLD ONES

Theodore W. Ruger*

For all of the fanfare and vitriol accompanying its passage last year, the Patient Protection and Affordable Care Act (PPACA) of 2010 is a statute that raises as many questions as it answers.¹ The Act significantly reshapes private health insurance regulation and the federal government's role in providing access to insurance for almost all Americans. But despite its prodigious length of almost 2,000 pages,² the details of the Act's new restrictions on insurers and health insurance exchanges that the Act creates remain amorphous pending the issuance of comprehensive administrative regulations. Crucial components of the new statute—its mandate for individuals to purchase health insurance³ and its expansion of Medicaid coverage in concert with state governments⁴—are the subject of constitutional challenge in multiple lawsuits filed by over a dozen states.⁵ Moreover, Republicans have pledged to make repeal of the Act a central plank of their platform in the fall 2010 elections and perhaps the 2012 presidential race.⁶ Finally, second-order effects such as the response of private employers to the new public subsidized backstop of the exchanges, are also highly uncertain and could radically change the cost profile of the new government involvement in health insurance.

In the face of such uncertainty, Dr. Theda Skocpol and Vanessa Williamson's illuminating essay in this volume provides several key vantage points for beginning to assess the Act's impact and meaning in the American political landscape.⁷ By invoking the powerful historical analog of the New Deal, Skocpol and Williamson highlight the Act's potentially transformative impact in terms of Americans' health care security and

* Professor of Law, University of Pennsylvania Law School.

1. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. *See id.*

3. *See id.* §§ 1501, 5000A.

4. *See id.* § 2001.

5. For a collection of legal documents relating to litigation by states in federal courts in both Florida and Virginia, see ACA Litigation Blog, <http://acalitigationblog.blogspot.com> (last visited August 31, 2010).

6. *See, e.g.,* Julian Walker, *Gingrich Urges Blocking Health Care*, VIRGINIAN-PILOT, May 24, 2010 (former Speaker predicting there was a 50-50 chance Republicans would repeal PPACA by 2013).

7. *See* Theda Skocpol & Vanessa Williamson, *Obama and The Transformation of U.S. Policy*, 42 ARIZ. ST. L.J. 1203 (2011).

health insurance solidarity.⁸ The Act's redistributive financing mechanisms and its restrictions on underwriting differentiation by private insurers⁹ mean that Americans are interconnected as never before in the nation's health insurance and delivery systems. As Skocpol and Williamson state, this is an important shift in the public policy of the United States.¹⁰ For decades the United States has stood alone in failing to guarantee access to millions of its poorest and sickest citizens. The fact that the Act goes most of the way toward rectifying this coverage gap, and does so in the distinctly redistributive manner that the authors describe, marks it as a landmark public policy achievement that is worthy of discussion in the same breath as the New Deal programs.

Yet the New Deal's value as a comparative exemplar in assessing the new Patient Protection Act lies in the major differences as well as the similarities between the two public policy events. The New Deal did more than redistribute resources within existing public and private structures—it also created and defined new legal and administrative institutions and norms, and in the process fundamentally transformed the relationship that American citizens and American companies had with the federal government.¹¹ Enacted onto what was in many areas a policy vacuum, at least as far as the federal government was concerned, major New Deal programs such as Social Security gained early and widespread public acceptance by conferring tangible benefits on most of the population where nothing meaningful had existed before.¹² Likewise, the various new regulatory agencies that the New Deal Congress created faced initial resistance from industry and the U.S. Supreme Court,¹³ but once established had the luxury of operating on a regulatory blank slate, which gave greater latitude to these agencies' early institutional choices.¹⁴

8. See *id.* at 1203–4, 1228–29.

9. See PPACA, §1201, 124 Stat. at 155 (defining exclusive permissible rating criteria for individual and small group markets).

10. See Skocpol & Williamson, *supra* note 7, at 1203.

11. See, e.g., 2 BRUCE ACKERMAN, *WE THE PEOPLE: TRANSFORMATIONS* 259–61 (1998) (explaining that the New Deal embodied “a sweeping redefinition of the aims and methods of American government”); Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342, 351 (2004) (describing the New Deal as a “paradigm shift” in American society and the role of the federal government).

12. See, e.g., MERTON C. BERNSTEIN & JOAN BRODSHAUG BERNSTEIN, *SOCIAL SECURITY: THE SYSTEM THAT WORKS* (1988) (discussing patterns of popular support for Social Security).

13. See, e.g., Michael Ariens, *A Thrice-Told Tale, or Felix the Cat*, 107 HARV. L. REV. 620 (1994) (describing initial Supreme Court resistance to New Deal programs).

14. See WILLIAM LEUCHTENBURG, *FRANKLIN D. ROOSEVELT AND THE NEW DEAL, 1932–40* (1963) (describing the regulatory initiatives undertaken by a panoply of new agencies).

None of this is true with respect to the new Patient Protection Act: it is fundamentally a gap-filling statute (though a sweeping one), aimed at closing significant loopholes in the complex existing architecture of public and private health insurance in the United States, and doing little to simplify or make more coherent the fragmented system that already exists. The Act cures two major shortfalls in current access to health insurance by expanding Medicaid dramatically to cover tens of millions of more people at or near the poverty line, and also through its exchange provisions will help many Americans with preexisting conditions gain access to health insurance.¹⁵ But in the immediate term it does little to rework the basic structure of the medical delivery system, replete with high levels of variation in physician practice and dramatic annual cost increases.¹⁶

Moreover, for all its breadth and length the Act is primarily about health insurance, not health care delivery. It leaves significant questions about the cost and quality of health care in the United States almost entirely unaddressed. For instance, the vast treatment discretion retained by individual physicians and other providers, and the large role for major corporations, are only faintly addressed in this statute, suggesting the need for another round of wrenching legislative debate before we truly witness a “New Deal” for American health care. As noted above, the PPACA admirably deals with key questions of insurance access for all that have languished unaddressed for too long. However, it largely leaves the existing medical delivery system as it finds it. A true “New Deal” for American medicine in the twenty-first century will necessarily involve modifying the way the health industry provides care, not merely the way society pays for it.

Additionally, the imposition of the Patient Protection Act’s terms onto a public-private structure already ossified and in turn defined by New Deal and Great Society programs, threatens to reduce the public’s enthusiasm, at least in the short run, for the changes it will produce. Expansion of health insurance for Americans has proceeded incrementally over the past seventy years since the New Deal. The first great expansion was of the number of Americans covered through their jobs by employment-based private health insurance: spurred by wartime wage freezes (that exempted benefit increases) and favorable tax treatment of health benefits, this trend rapidly

15. See KAISER FAMILY FOUND., SUMMARY OF COVERAGE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), available at <http://www.kff.org/healthreform/upload/8023-R.pdf>.

16. On variation in medical practice and associated cost complications, see, e.g., Elliott S. Fischer et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288 (2003).

expanded the number of Americans with private health insurance from 20.6 million in 1940 to 142.3 million in 1950.¹⁷ In 1965 came the addition of the popular Medicare program, ensuring that most Americans over the age of 65 would have access to health insurance.¹⁸ Taken together, the fact that most Americans already have access to health insurance has frustrated previous efforts to universalize coverage, and may reduce public support for the incremental coverage expansions of the PPACA.

Further extensions of the authors' New Deal comparison reveal other points of similarity and difference. This brief response aims to highlight a few of these similarities and differences. Of specific interest is the authors' focus on the redistributive features of the new statute.¹⁹ As Skocpol and Williamson describe, the Act redistributes resources for health insurance coverage in a manner that is novel and important.²⁰ Like the major New Deal entitlement and safety net programs, wealthier Americans will be asked to pay more in taxes to guarantee a decent minimum health insurance system for almost all Americans.²¹ But the redistribution is also subtle and multifaceted: like Social Security, perhaps the most notable and enduring of the New Deal programs, the redistributive features of the Patient Protection Act are both multimodal and intentionally obscure. The Act's terms effectuate at least three redistributions to a greater extent than preexisting law: (1) from the wealthier to the poorer; (2) from the younger to the older; and (3) from the healthier to the sicker.

Like Social Security and Medicare, the fact that the Act embodies multiple pathways of redistribution as opposed to even greater tax increases on wealthy Americans helped to facilitate its passage.²² The Act, however, is more redistributive than Social Security. To the extent it redistributes not just from the young to the old but significantly also from the wealthy to the poor and from the healthy to the sick. But more so than the redistribution inherent in Social Security, the multiple redistributions effectuated by the Patient Protection Act also raise some nontrivial theoretical concerns, as

17. See David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006).

18. See John K. Iglehart, *The American Health Care System: Medicare*, 340 NEW ENG. J. MED. 327 (1999).

19. See Skocpol & Williamson, *supra* note 7, at 1203–04.

20. *Id.*

21. See Kathleen Pender, *How Health Reforms Will Change Taxes*, S.F. CHRON., Apr. 4, 2010, at E1 (noting that high-earning Americans “will pay for a good chunk of health care reform through higher Medicare taxes on their earnings and a new Medicare tax on investment income”).

22. Cf. *Demography and the Economy: As Boomers Wrinkle*, THE ECONOMIST, Jan. 1, 2011 (noting the unpopularity of the “unprecedented increases in taxes” potentially required to finance health and other benefits for aging Americans).

well as the potential to sow public discontent and political rejection. For instance, redistribution based on income can be justified by economic theories such as the diminishing marginal value of extra income in ways that are not directly transferable to redistribution from nonwealthy healthy young people to sicker people at the same or greater income level.²³

I will take the Act's three main redistributive methods in turn. First, as noted by Professors Skocpol and Williamson, the new statute more sharply redistributes resources for health insurance based on income.²⁴ One clear implication of the bill is that wealthier Americans will pay more to subsidize the health care of poorer citizens, both through the Medicaid expansion and through the public subsidies for exchange participation. Whether such redistribution goes too far, or not far enough, are questions of degree that will be debated in the years ahead. This debate will intensify as increasing cost pressures may cause future rounds of increased financing. As is well-documented and frequently discussed, health care cost increases are growing at significantly greater rate than the overall inflation rate, and health care accounts for an ever-increasing percentage of GDP, making the need to control costs within the next decade more pressing.²⁵

Notably, however, the expanded coverage and underwriting reform that the Act enforces are also funded by two other, less visible, redistributive techniques: increased redistribution of resources (1) from healthy people (including those making far less than \$100,000 per year) to sicker people; and (2) from younger Americans to older individuals. These other redistributive vectors apply to both the public and private health insurance provisions of the bill, but are evident most starkly in the private market reforms and related sections of the statute.²⁶

The Act redistributes based on age in the private insurance market by placing "age-rating" limitations on health insurance pricing coupled with the mandate that all individuals purchase health insurance if able.²⁷ From an

23. For a discussion of these concerns in the context of individual mandates, see Allison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 33–34 (2010) (exploring "good reasons to believe it is not fair to ask the young to bear the costs of care for those older and sicker than themselves" though ultimately coming out in favor of individual mandates).

24. Skocpol & Williamson, *supra* note 7, at 1203–04.

25. See KAISER FAMILY FOUNDATION, TRENDS IN HEALTH CARE COSTS AND SPENDING (2009), available at http://www.kff.org/insurance/upload/7692_02.pdf (documenting projection that under current trends by 2018 U.S. healthcare spending will exceed 20% of GDP and be over \$13,000 per capita).

26. See PPACA, § 1201, 124 Stat. at 154–61.

27. See §§ 1501 and 5000A, 124 Stat. at 242–49 (individual mandate) and § 1201, 124 Stat. at 154–61 (defining exclusive permissible rating criteria for individual and small group markets).

actuarial (predictive) perspective, a healthy sixty-three year-old person costs much more to insure than a healthy twenty-eight year-old person.²⁸ If insurance companies could price that risk accurately, as many attempted to do before passage of the Act, they would charge the fifty-eight year-old significantly more than the twenty-eight year-old.²⁹ By limiting age-rating to a factor of three to one, the Act requires a forced subsidy, or quasi-tax, on younger people who buy insurance and pay more than the actuarial risk they present.³⁰ This private market subsidy is an addition to the preexisting age-based redistribution effectuated through the large-scale public programs such as Medicare and Social Security, which are entitlements for older individuals funded by wage taxes on younger workers.³¹

There is nothing inherently unethical, or particularly unusual, about such upward redistribution of resources within a nation's health system. Many other nations with universal health care finance their systems significantly through regressive wage-based payment schemes rather than through a more progressive income tax.³² And of course the quintessential New Deal program, Social Security, is funded in large part through contributions on a fixed portion of income currently capped at \$106,800.³³ But the upward redistribution is further compounded in the health insurance context by the fact that people in their last few years of life account for a high proportion of overall health expenditures.³⁴

Such age-based redistribution is acceptable as part of a durable intergenerational deal, where workers pay (otherwise regressive) amounts

28. See Micah Hartman et al., *U.S. Health Spending by Age, Selected Years Through 2004*, 27 HEALTH AFF. 1 (documenting fact that per-person spending by those 65 and older was over five times that of per capita spending for children and over three times that of "working age" adults), <http://content.healthaffairs.org/content/27/1/w1.full.pdf>.

29. See Anna Wilde Mathews, *Effort to Assist Older Voters May Raise Costs for the Young*, WALL ST. J., Nov. 10, 2009, at A4 (noting that in states without age-rating restrictions "older people may pay five or six times as much" as younger insureds for the same policy).

30. See PPACA, § 1201, 124 Stat. at 154–61.

31. See Michael Doran, *Intergenerational Equity in Fiscal Policy Reform*, 61 TAX L. REV. 241, 244–52 (2008) (specifying the manner in which the early amendments to Social Security effectuated an ongoing intergenerational transfer of wealth).

32. See Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 433–35 (2001) (explaining that Germany, the United States, and many countries in Central and Latin American and Asia fund public insurance programs under a Bismarckian "social insurance" model that is funded by payroll contributions).

33. See Doran, *supra* note 31, at 248–53; see also Social Security Administration, *Contribution and Benefit Base*, <http://www.ssa.gov/OACT/COLA/cbb.html> (last visited Oct. 8, 2010).

34. See, e.g., Christopher Hogan et al., *Medicare Beneficiaries' Costs of Care in the Last Year of Life*, 20 HEALTH AFF. 188, 190 (2001).

now in order to be taken care of in the future. For most Americans who worked during the twentieth century, for instance, the redistributive component of Social Security operated over decades as a kind of self-centered distribution: people's younger selves were taxed in order to provide for their older selves.³⁵ Likewise, this has been the basic assumption for the Medicare program that has existed since the 1960s. This intertemporal individual redistribution from an earlier stage of life to a later one worked so long as the cost profile of expenditures for older individuals matched the pool of new incoming payments from existing workers.

The challenge in the health insurance context will be to sustain the system so as to make good on this intergenerational bargain. Health care costs in the United States are increasing at a far greater pace than gross domestic product (GDP) growth, making the current system of finance and delivery unsustainable beyond the next decade or two at the latest. Numerous cost estimates show a Medicare system under deep fiscal strain, with current predictions holding that the Medicare trust fund will be insolvent within two decades under current spending levels, even accounting for the cost saving components of the new health statute.³⁶ Private health insurance spending is increasing at an even greater rate in the past decade.³⁷

In reality, then, absent systemic change many younger Americans will be paying now for a health care system that will not exist when they most need it later in life. They faced this prospect before 2010 under the existing Medicare financing mechanism; but the new Patient Protection Act makes them pay also to support rising premiums in the private sector by virtue of the restrictions on actuarially accurate age-rating.³⁸ With the exception of some tentative steps toward reducing Medicare payment costs years from now,³⁹ the new Act's provisions only indirectly stem these cost increases. Future legislation, and determined political effort, will likely be necessary before the systemic drivers of cost increase are brought under control.

Much of the foregoing analysis applies as well to the Act's third major mechanism of redistribution—from healthier individuals to sicker individuals. This sort of redistribution is inherent in any health insurance pool, private or public, and is unobjectionable on several different

35. See Doran, *supra* note 31, at 244–52.

36. See Jackie Calmes, *Law Will Reform Medicare Fund, Report Says*, N.Y. TIMES, Aug. 6, 2010, available at <http://www.nytimes.com/2010/08/06/health/policy/06medicare.html>.

37. See Drew Altman, Larry Levitt & Gary Claxton, *An Actuarial Rorschach Test* (2010), available at http://www.kff.org/pullingittogether/021610_altman.cfm.

38. See Mathews, *supra* note 29 (noting that in states without age-rating restrictions “older people may pay five or six times as much” as younger insureds for the same policy).

39. See PPACA §§ 3401–3403, 124 Stat. at 480–507.

justifications. The only questions are ones of degree and modality: is “taxing” health, as the Act does by restricting insurers’ ability to price according to health risk and preexisting illness, more or less regressive than taxing income to pay for those with ill health? A system that financed care for the poor and sick entirely through a progressive income or wealth tax might well produce a more equitable distribution and—given the diminishing marginal value of money—be relatively more optimal from an overall utility perspective. But such a system would be politically more difficult to enact and operationalize.

In sum, the authors are correct to note that the passage of the PPACA stands, for the time being at least, as a “remarkable achievement”—one ambitious in scope and potentially transformative going forward. But as of this writing it is far from clear whether the Act will be eventually regarded as “another New Deal.” The New Deal transformation was welcomed by a larger majority of Americans at the time than the PPACA currently enjoys, and soon attained even higher levels of public support.⁴⁰ By contrast, the PPACA stands on wobbly footing in the fall of 2010, with the opposition party making political gains in part due to pledges to repeal it. The elections of 2010 and 2012 will go far in either entrenching the PPACA as a true “New Deal” for American health care or in setting up the political preconditions for its unraveling. Whatever the result, it is clear that important chapters in American health care reform remain to be written.

40. See, e.g., Laura Kalman, *Law, Politics, and the New Deal(s)*, 108 YALE L.J. 2165, 2170–71 (1999) (noting the “stunning popularity” of President Roosevelt and his early New Deal reforms as manifested in the midterm elections of 1934).