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OBAMACARE: THE BIRDS STILL SING AS FREEDOM ERODES

JOHN S. HOFF*

President Obama has taunted those who say that the legislation overhauling the American health care system is a disaster ("Armageddon"). He observed that the birds are still singing and that no asteroids have hit the earth.[1] This clever statement of the obvious is an entirely evasive rhetorical device.

The effects of the legislation will not be felt for some time. The main provisions do not begin to kick in until 2014,[2] but most observers believe that when they do, the new entitlement will increase government spending far beyond what has been estimated and dangerously explode the deficit. As if that were not bad enough, the legislation will significantly reduce Americans' freedom. Even then, the birds still will be singing (they sing also in countries governed by totalitarian regimes), but Americans will have lost a chunk of their individual freedom.

The Administration has attempted to sell the new program by promising that it increases peoples' choices, reins in abuses of insurance companies, and provides coverage to most of the uninsured. But the bill is a grand opportunity lost. There are better ways to achieve these goals. Increasing individuals' ability to buy and own their own insurance could provide coverage for the uninsured and lay the foundation for real reform of the health care system in a fiscally responsible way. President Obama and his colleagues in the Congressional leadership, however, rejected this approach and forced through a program that enhances government power and reduces individual choice.[3]

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1. David M. Herszenhorn, *Obama to Boehner: Where's the Armageddon?*, N.Y. TIMES (Apr. 1, 2010, 5:59 PM), http://prescriptions.blogs.nytimes.com/2010/04/01/obama-to-boehner-wheres-the-armageddon/.

2. *See* Memorandum from Richard S. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., on the Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended (Apr. 22, 2010), http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

3. The legislation is entitled the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as

The new system turns health insurance companies into agents of the federal government. The government determines what policies they may sell through the new American Health Benefit Exchanges; only these policies are eligible for subsidies to purchasers.[4] Qualified plans must fit into homogenized categories labeled platinum, gold, silver, and bronze, with the only variation being the level of copayments.[5] The government defines the "essential health benefits" that must be covered.[6] Indeed, the government is obliged to determine what is the "appropriate balance" among various categories of health services and thus is obliged to set the percentage of coverage for inpatient care, outpatient care, laboratory services, and the other categories of service listed in PPACA and any added by the Department of Health and Human Services.[7] The policies must cover preventive care without copayments; the government defines preventive care.[8] The government will determine the composition of insurers' risk pools,[9] and it will determine the geographic areas to be used in setting rates.[10]

Insurers will be required to accept everyone who applies for coverage.[11] They must charge everyone the same premium, regardless of expected health care usage, with adjustment only for family size, age (less than the actual cost differential), and smoking status.[12]

At the same time, the government will also control how much the insurers can charge. The new law requires insurers to spend a stated percentage of premiums on claims and quality improvement efforts.[13] This acts as a limit on insurers' profits and on the amount they can spend on activities that the government decides are not related to claims or quality improvement. Insurers may have to curtail programs to manage their members' care and efforts to prevent fraud and to reduce costs. The government will also ensure that "unreasonable increases" in premi-

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amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.). For ease of reference, PPACA as used here also includes amendments made to it by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

4. *See generally* PPACA §§ 1001–1563, 124 Stat. at 130–271.
5. *Id.* § 1302(d), 124 Stat. at 167–68.
6. *Id.* § 1302, 124 Stat. at 163–68.
7. *Id.* § 1302(b), 124 Stat. at 163–64.
8. *Id.* § 1001, 124 Stat. at 131–32.
9. *Id.* § 1312(c), 124 Stat. at 182.
10. *Id.* § 1201, 124 Stat. at 155.
11. *Id.* § 1201, 124 Stat. at 154–55.
12. *Id.* § 1201, 124 Stat. at 155.
13. *Id.* § 1001, 124 Stat. at 137.

ums are publicized.[14] There is no standard in the statute for what is an unreasonable increase.

The federal government will also control insurance companies through the exchanges through which individual and small group insurance will be sold (the states are given the option of including employees of large employers).[15] Each state is required to organize an exchange (if it does not, the federal government will set up one for it).[16] The exchange will determine which insurance companies can participate.[17] The federal government will give money to states to support state rate-review programs.[18] States receiving this money must make recommendations to the exchange about excluding insurers that show a pattern of "unjustified" increases.[19] It is expected that the exchanges will use their purchasing power to bargain with plans;[20] with the power to include or exclude plans from participation, they can insist that insurers do their bidding on any matter. It is a simple equation: do as the exchange wants, or do not sell through the exchange. While there is a pretense that the exchanges are state activities, the federal government sets the standards for their operation and for the certification of plans to participate in them. Rules promulgated by the federal government override inconsistent rules of the exchanges.[21] Insurers are required to charge the same rates for people buying in the exchange and for people who buy outside the exchange.[22]

On the surface, this complex and pervasive regulatory structure appears to involve only insurers. But it affects everyone. The regulatory scheme restricts what products the insurance companies can sell; they can offer only policies that fit the federal mold. Any deviation to accommodate the market must meet federal standards. This will impair their ability to meet consumer desires and will reduce the choices available to people. Squeezed between implicit or actual price controls and the federal government's ability to dictate what they must cover, the insurers may

14. *Id.* § 1003, 124 Stat. at 139–40. *See also id.* § 1311(e)(2), 124 Stat. at 178 ("[H]ealth plans seeking certification as qualified health plans [must] submit a justification for any premium increase prior to implementation of the increase.").

15. *Id.* § 1312(f), 124 Stat. at 183.

16. *Id.* §§ 1311, 1321, 124 Stat. at 173–81, 186–87.

17. *Id.* § 1311(d), 124 Stat. at 176–78.

18. *Id.* § 1003, 124 Stat. at 140.

19. *Id.* § 1003, 124 Stat. at 139.

20. *See Six Ways Health Reform will Help Small Businesses*, WHITE HOUSE, http://whitehouse.gov/healthreform/small-business (last visited Apr. 2, 2011).

21. PPACA § 1311(k), 124 Stat. at 181.

22. *Id.* § 1301(a)(1)(C)(iii), 124 Stat. at 163.

not be able to survive in business. The federal government may decide it is not worth maintaining insurance companies as *de facto* agents and take over the payment system itself (with insurance companies being reduced explicitly to contract claims-paying agents). The single-payer system that many liberals prefer will thus be achieved. The government will directly control everyone's health care.

Even before the system deteriorates into a single payer, the government will be requiring people to buy insurance that it determines they should have, and at the price it effectively sets. This scheme assumes the wisdom of regulators to make a very fine calibration, and to do it for everyone, regardless of their varying circumstances. They are certain to be wrong in many cases.

The government is forcing people to buy insurance coverage that is more comprehensive and more expensive than they would choose on their own. This is particularly true with respect to the young and healthy. By requiring insurers to charge the same premium for all members of a plan regardless of health risk and with only a modest adjustment for age, the new system dictates that the young and healthy subsidize the cost of insurance for those who are older or sicker. Significantly, the mandate on individuals to buy insurance is not an effort to be certain that people have coverage to protect themselves. The mandate in the current scheme is a way of taxing the young and healthy. Those who have healthy life styles will be subsidizing insurance for those who engage in risky behavior that results in illness and increases their health costs.

The new system reduces individuals' choices in a more fundamental way. When insurance companies have to attract customers (employers or individuals), they must develop a product that best satisfies consumer needs at a price they are willing to pay given the economic context in which they operate. Buyers can choose among competing products that have different mechanisms for reducing costs and different coverages. Under the new system, however, the federal government makes these decisions—in the first instance by Congress and then by the government agencies that will implement the legislation.

The federal government is the main decision maker, replacing insurers, customers, and state regulators. States have a role—but only if consistent with federal requirements. Insurers, employers, and consumers have choices—but only in the tight box constructed by the federal government. Government decisions will increasingly supplant individual choice.

The government does not have to meet a market test. The only test it must meet is a political one—and of course it has been politically advantageous to offer benefits and require others to pay the cost (those buying insurance and the taxpayer subsidizing the purchase).

Stakeholders will attempt to influence the government's decisions to win favorable treatment for themselves. There will be an ongoing orgy of lobbying. While people may find this distressing, it is inevitable that people directly affected by government action attempt to influence those decisions. The lobbying and deal making that greased enactment of the new regime were not ended by its passage. On the contrary, they will be a permanent feature of the health care landscape.

Special interests with the money to successfully lobby for a favorable ruling by an administrative agency or a change in the law by Congress will benefit. Individuals' choices will be limited to what the government and the special interests agree on. The biggest loss of freedom that the new program entails is that individuals' ability to choose what they want from competing insurance plans is subordinated to government decisions made on the premise that it knows best what individuals should have and how much they should pay. The scheme is the quintessential one-size-fits-all model. Americans will bridle at this approach. They already are, even though the birds are still singing.