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# The Consequences of Repealing Health Care Reform in Early 2013

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# THE CONSEQUENCES OF REPEALING HEALTH CARE REFORM IN EARLY 2013

J. ANGELO DESANTIS AND GABRIEL RAVEL\*

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#### ABSTRACT

This Article evaluates the consequences of an early 2013 repeal of the enacted Health Care Reform. We consider the Act’s significant provisions that will have taken effect by 2013. For implemented provisions, we review their current effect on coverage, costs, and care. We then evaluate the practical consequence of the loss of those provisions. For provisions that have not yet taken effect, but will before 2013, we evaluate their projected effects in considering the consequences of repeal. Finally, for provisions that will not take effect before 2014, but where significant funds and effort will be expended prior to 2014, we evaluate those costs in considering the consequences of repeal.

We conclude that the loss of many provisions would cause a significant impact. However, not all segments of the population would be equally affected by a pre-2014 repeal. Americans with basic coverage stand to lose the most. For example, changes such as the extension of dependent coverage and restrictions on annual limits have greatly increased the value of basic coverage for those who have it. Medicare recipients would similarly stand to lose from a 2013 repeal. But for those unable to afford basic comprehensive coverage, a 2013 repeal would comparatively have less effect—though a repeal after 2014 would significantly impact this group.

#### I. INTRODUCTION: THE THREAT OF REPEAL IN 2013

On January 19, 2011, after Republicans took control of the House of Representatives and gained six Senate seats, the House voted to repeal Health Care Reform. The bill was exceptionally simple: “[Health Care Reform is] repealed, and the provisions of law amended or repealed by such Act are restored or revived as if such Act had not been enacted.”<sup>1</sup> But with the Senate controlled by Democrats and President Obama in the White House, the vote was merely symbolic. Indeed, so long as President Obama is in office, the Patient Protection and Affordable Care Act

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<sup>1</sup> Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (2011) (However, as discussed below, as broad as H.R. 2 was, it did not purport to repeal the ACA’s changes to higher education funding.).

and Health Care and Education Reconciliation Act (together “ACA” or Affordable Care Act) are not likely to be repealed. The President can veto any repeal attempt, and those willing to repeal are unlikely to achieve a supermajority in both houses of Congress. But the 2012 elections could significantly change this calculation.

All major Republican presidential candidates have pledged to repeal the ACA. Though as of this writing, most candidates have dropped out, and Mitt Romney is the presumptive nominee, every significant contender (Perry<sup>2</sup>, Bachmann<sup>3</sup>, Cain<sup>4</sup>, Romney<sup>5</sup>, Paul<sup>6</sup>, Huntsman<sup>7</sup>, Gingrich<sup>8</sup>, and Santorum<sup>9</sup>) has vowed to repeal the ACA if elected. Indeed the ACA served as a punching bag at the Republican debates: “ObamaCare is clearly leading to job-killing regulations, not job-creating

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<sup>2</sup> See RICK PERRY FOR PRESIDENT 2012, <http://www.rickperry.org/issues/healthcare/> (last visited Jan. 17, 2012). “If elected, Perry will repeal Obamacare—a misguided, unconstitutional and unsustainable government takeover of our health care that will undermine patient quality, increase red tape and send costs skyrocketing for taxpayers, patients and healthcare providers.” *Id.*

<sup>3</sup> See TEAM BACHMANN, <http://www.michelebachmann.com/issues/> (last visited Jan. 17, 2012). “As President, I [Michele Bachmann] will not rest until Obamacare is repealed, and will work to unleash the power of medical innovation and personal choice in producing better treatments and more cures that mean better outcomes at lower cost.” *Id.*

<sup>4</sup> See *Herman Cain on Health Care*, ON THE ISSUES: EVERY POLITICAL LEADER ON EVERY ISSUE, [http://www.issues2000.org/2012/Herman\\_Cain\\_Health\\_Care.htm](http://www.issues2000.org/2012/Herman_Cain_Health_Care.htm) (last visited Apr. 16, 2012). “Q: What is your plan to reduce the cost of health care so that our insurance premiums and other related costs can also be reduced? CAIN: First, repeal Obamacare in its entirety.” *Id.*

<sup>5</sup> See MITT ROMNEY FOR PRESIDENT, <http://www.mittromney.com/issues/health-care> (last visited Jan. 17, 2012). “Mitt Romney believes that Obamacare must be repealed. On his first day in office, he will issue an executive order paving the way for waivers from Obamacare for all 50 states. Subsequently, he will call on Congress to fully repeal Obamacare, and advocate reforms that return power to the states, improve access by slowing health care cost increases, and make health insurance portable and flexible for today’s economy.” *Id.*

<sup>6</sup> See RON PAUL 2012 OFFICIAL CAMPAIGN WEBSITE, <http://www.ronpaul2012.com/the-issues/health-care/> (last visited Jan. 17, 2012). “[Ron Paul] will work with Congress to: Repeal ObamaCare and end its unconstitutional mandate that all Americans must carry only government-approved health insurance or answer to the IRS.” *Id.*

<sup>7</sup> See JON HUNTSMAN: PRESIDENT 2012, <http://www.jon2012.com/blog/Tags/Healthcare> (last visited Jan. 17, 2012). “There are two general approaches to reform. One is to use the heavy hand of government via strict mandates and regulations, which is what the federal government has done, and which Jon [Huntsman] has forcefully said he’d repeal.” *Id.*

<sup>8</sup> See NEWT2012, <http://www.newt.org/solutions/healthcare> (last visited Apr. 16, 2012). “We must repeal and replace the [L]eft’s big government health bill with real solutions that will lower costs and improve health outcomes.” *Id.*

<sup>9</sup> See RICK SANTORUM FOR PRESIDENT, <http://www.ricksantorum.com/repeal-and-replace-obamacare-patient-centered-healthcare> (last visited Jan. 17, 2012). “Priority number 1 = repeal ObamaCare and its burdensome job-destroying bureaucracy, taxes, mandates, and heavy-handed government decision-making.” *Id.*

regulations;”<sup>10</sup> “It’s bad law. It’s bad constitutional law. It’s bad medicine;”<sup>11</sup> “I think we all agree that Obamacare must be repealed because it is a disaster;”<sup>12</sup> “we will lose 1.6 million jobs over five years if we keep ObamaCare;”<sup>13</sup> “It’s a 2,000-page bill that takes over health care for all the American people.”<sup>14</sup>

Taking these candidates at their word, the 2012 election will not only determine control of the White House, but the fate of the ACA.<sup>15</sup> If a candidate willing to repeal the ACA is elected, along with a like-minded majority in the Senate, the earliest repeal could occur is January 20, 2013—the beginning of the 2013 term.<sup>16</sup>

The potential of an early 2013 repeal raises the question: What are the consequences of a 2013 repeal of the ACA? By 2013, most of the blockbuster reform provisions—the insurance mandate, the state-based-exchanges, the individual tax credits, preexisting conditions protection for adults, and the Medicaid expansions—will not have taken effect. Yet many significant provisions of the ACA will have taken effect. Thus, a 2013 repeal will necessarily have some effect. It will not simply be as though the ACA had never been enacted.

This Article explores the consequences of a 2013 repeal of the ACA by evaluating the Act’s significant provisions that have taken effect before 2013. For provisions that are currently in effect, we review their effect on coverage, costs, and care. We then evaluate the practical consequence of the loss of those provisions. For provisions that have not taken effect, but will before 2013, we evaluate their projected effects in considering the consequences of repeal. Finally, for provisions that will not take effect before 2014, but where significant funds and effort will be expended prior to 2014, we evaluate those costs in considering the consequences of repeal.

In Part II, we discuss how the current Constitutional change to the ACA relates to the question of consequences of a 2013 repeal. In Part III, we provide an overview of the ACA’s provisions, including those that will not take effect before 2013. In Part IV, we identify important provisions that will have taken effect by 2013, and consider the effect of their individual loss through repeal. In Part V, we take a broader view and consider the combined loss of these provisions.

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<sup>10</sup> *The Republican Debate at the Reagan Library*, N.Y. TIMES, Sept. 7, 2011, available at <http://www.nytimes.com/2011/09/08/us/politics/08republican-debate-text.html?pagewanted=all>.

<sup>11</sup> *The Ames Republican Debate Transcript: Everything They Said That You Missed*, L.A. TIMES, Aug. 13, 2011, available at <http://latimesblogs.latimes.com/washington/2011/08/ames-debate-romney-bachmann-paul-huntsman-santorum-gingrich-pawlenty-cain.html>.

<sup>12</sup> *Full Transcript CNN Western Republican Presidential Debate*, CNN (Oct. 18, 2011), <http://archives.cnn.com/TRANSCRIPTS/1110/18/se.05.html>.

<sup>13</sup> *Full Transcript: ABC News Iowa Republican Debate*, ABC NEWS (Dec. 11, 2011), <http://abcnews.go.com/Politics/full-transcript-abc-news-iowa-republican-debate/story?id=15134849&singlePage=true#.TueZFtU6J8E>.

<sup>14</sup> *Id.*

<sup>15</sup> See David Blumenthal, *Perspective, 2012 — A Watershed Election for Health Care*, 365 NEW ENG. J. MED. 2047, 2047 (2011).

<sup>16</sup> See U.S. CONST. amend. XX § 1.

We conclude that repeal would be enormously disruptive. Significant time, effort, and money invested in erecting the foundation of the major ACA provisions would be wasted. Many Americans who gained insurance under the ACA would stand to lose their coverage. New consumer protections afforded to those with coverage would disappear. Still, repeal will not affect all segments of the population equally. The uninsured or the underinsured comparatively stand to lose less than those with comprehensive coverage, as most provisions effecting Americans of lesser means take effect in 2014.

We hope that this analysis of the effects of a 2013 repeal will prove useful in the lead up to the 2012 election.

## II. THE CONSEQUENCES OF REPEAL AND THE CONSTITUTIONAL CHALLENGE TO THE AFFORDABLE CARE ACT

This Article focuses on the threat of repeal arising from the 2013 elections, but shortly before publication, the Supreme Court raised the specter of the ACA being struck down. During oral arguments, the conservative justices appeared receptive to arguments that key portions of the ACA were unconstitutional. This willingness was surprising given the near-unanimous conclusion of Constitutional scholars that the ACA is constitutional.<sup>17</sup> We briefly address how this turn of events relates to our analysis.

The Court is considering not only the constitutionality of the individual mandate, but also the Medicaid expansion, and the severability of these provisions.<sup>18</sup> Several outcomes are possible. The Court could strike the individual mandate or Medicaid expansion or both—leaving the other provisions in place. It could also repeal the entire ACA. Indeed, during arguments, Justices Scalia sardonically inquired: “You really want us to go through these 2,700 pages? . . . Is this not totally unrealistic? That we’re going to go through this enormous bill item by item and decide [the severability of] each one?”<sup>19</sup>

This Article effectively addresses the consequences of the Court striking down the ACA in full. A scenario where the Court strikes only a portion of the ACA potentially raises a more complicated question than we address here. The loss of a core provision could give Congress and the President no choice but to remove or

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<sup>17</sup> See e.g., Vikram David Amar, *Reflections on the Doctrinal and Big-Picture Issues Raised by the Constitutional Challenges to the Patient Protection and Affordable Care Act (Obamacare)*, 6 FIU L. REV. 9, 11 (2010) (Associate Dean & Professor Amar provide a fascinating discussion of the constitutionality of the ACA, ultimately leaving the reader persuaded that the individual mandate is within Congress’s power.); Akhil Reed Amar, *Constitutional Objections to Obamacare Don’t Hold Up*, L.A. TIMES, Jan 20, 2010, available at <http://articles.latimes.com/2010/jan/20/opinion/la-oe-amar20-2010jan20> (“I have spent the last three decades studying the Constitution, and the current plan easily passes constitutional muster”); Erwin Chemerinsky, *A Mandate’s Fate*, L.A. TIMES, Nov. 15, 2011, available at <http://articles.latimes.com/2011/nov/15/opinion/la-oe-chermerinsky-healthcare-20111115> (“Under current constitutional law, this should be an easy case to predict—the law is clearly constitutional.”).

<sup>18</sup> The Court is also considering whether the Anti-Injunction Act bars these challenge. But during arguments, the Court did not appear receptive to that argument.

<sup>19</sup> Transcript of Oral Argument.

rework other portions of the ACA. Without the mandate, adverse selection<sup>20</sup> could make the preexisting conditions protections for adults unworkable. Still, experts have suggested alternatives to the mandate including: limited enrollment periods or late enrollment penalties; encouraging enrollment through public outreach, education and enrollment assistance; and tying coverage to one's credit score or eligibility for government services.<sup>21</sup> Moreover, the relatively small size of the penalty for failing to comply with the individual mandate suggests that it is more a psychological than a real penalty, and therefore its removal might not affect individual behavior significantly.<sup>22</sup> Whether provisions that depend on the mandate are removed, or whether an alternative to the mandate is enacted, will likely depend on the will and makeup of Congress.

The many options available to cure the loss of an important ACA provision illustrate the complexity of evaluating the consequences of the loss of the individual mandate or Medicaid expansion. We do not attempt that analysis here, but that that analysis would require separately evaluating the ACA's individual provisions to determine whether discrete provisions could exist independent of the individual mandate—the same analysis that Justice Scalia suggested was “totally unrealistic.”

But determining which provisions are inextricably linked to the individual mandate and Medicaid expansion may not be as daunting as Justice Scalia suggests. For most provisions, it is relatively clear whether the provision can function absent the individual mandate. For example, provisions relating to Medicare do not run the risk of encouraging adverse selection and thus can operate independently of the individual mandate. Similarly, medical loss ratio requirements are unlikely to require the mandate to function. Other provisions, such as the protections for adults with preexisting conditions will likely spur adverse selection and thus require the mandate or a similar strong insurance incentive.

Ultimately, while the oral arguments gave us cause to reconsider whether the 2012 election is the predominate threat to the ACA, the overarching analysis does not change. Indeed, our analysis, by separately evaluating individual ACA provisions, may mirror and provide guidance should the Court strike down the ACA's individual mandate or Medicaid expansion.

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<sup>20</sup> Adverse selection is a version of the free-rider dilemma. If individuals are not required to purchase health insurance, only those who are likely to need it will purchase it. In practice, this means individuals with pre-existing conditions and other health needs will purchase insurance and healthy individuals will not. This phenomenon forces issuers to raise premiums in order to cover the cost of paying the claims of higher-risk individuals.

<sup>21</sup> See Andrew G. Simpson, *9 Alternatives to Individual Health Insurance Mandate; Will They Work?*, INS. J., Mar. 29, 2011, available at <http://www.insurancejournal.com/news/national/2011/03/29/192080.htm>.

<sup>22</sup> Penalties for failure to maintain coverage are phased in over three years; by 2016 the penalty will be in full effect and will equal the greater of 2.5% of an individual's taxable income, or \$695 (indexed to inflation). 26 U.S.C. § 5000A (Supp. 2010). In 2014, the penalty is the greater of 1% of taxable income or \$95; in 2015: 2% or \$325. *Id.* When the penalty is in full effect an individual making \$50,000 will pay about \$1,000 (not all of the \$50,000 income is included as taxable income).

### III. AN OVERVIEW OF THE AFFORDABLE CARE ACT

In evaluating the consequences of the loss of individual provisions of the ACA, it is useful to consider the provisions that largely constitute the ACA, including provisions that do not take effect before 2013. We discuss these provisions as they appear in the Reform bills. We also review how the ACA aims to expand coverage while reducing costs.

#### A. *Contents of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010*

The original Health Care Reform bill, the Patient Protection and Affordable Care Act contains ten titles, but may be better thought of as eight individual sections. The tenth is the manager's amendments amending the previous sections and the eighth is the CLASS act, a disability insurance program that the Obama administration has chosen not to implement.<sup>23</sup> The Health Care and Education Reconciliation Act of 2010, which modifies the original Patient Protection Act, contains two titles. The titles with our descriptors are as follows:

##### **The Patient Protection and Affordable Care Act**

- I. Quality, Affordable Health Care for All Americans (The well-known provisions including new patient protections, cost reductions, and the individual and business mandates.)
- II. Role of Public Programs (Major expansions to Medicaid eligibility, and changes to other government programs.)
- III. Improving the Quality and Efficiency of Health Care (Medicare cost reduction measures and provisions related to Medicare payments.)
- IV. Prevention of Chronic Disease and Improving Public Health (Programs aimed at reducing costs by making Americans healthier.)
- V. Health Care Workforce (Measures designed to create enough health care workers to accomplish the aims of the ACA.)
- VI. Transparency and Program Integrity (Measures designed to crack down on fraud with regard to care providers, nursing homes, long-term facilities, and Medicare and Medicaid providers.)
- VII. Improving Access to Innovative Medical Therapies (Pharmaceutical industry changes.)
- VIII. CLASS Act (A voluntary disability insurance program not enforced by the Obama administration.)
- IX. Revenue Provisions (New taxes.)
- X. Strengthening Quality, Affordable Health Care for All Americans (The manager's amendments.)

##### **The Health Care and Education Reconciliation Act of 2010**

- I. Coverage, Medicare, Medicaid, and Revenues (Increases tax credits for purchasing coverage, implements additional changes to Medicare and Medicaid, and imposes new taxes.)
- II. Education and Health (Student loan reforms including the termination of the Federal Family Education Loan Program.)

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<sup>23</sup> See Robert Pear, *Health Law to Be Revised by Ending a Program*, N.Y. TIMES, Oct. 14, 2011, available at [http://www.nytimes.com/2011/10/15/health/policy/15health.html?\\_r=1](http://www.nytimes.com/2011/10/15/health/policy/15health.html?_r=1).



Title I of the Patient Protection and Affordable Care Act contains many of the most transformative and best-known provisions in the ACA. It imposes, *inter alia*, the individual mandate requiring most Americans, by 2014, to maintain coverage providing minimum essential benefits.<sup>24</sup> It similarly assesses a penalty on most employers, with at least fifty employees, that do not provide employees with credible coverage.<sup>25</sup> It creates state-based insurance exchanges for individuals and small businesses to buy coverage.<sup>26</sup> It defines the minimum benefits that policies sold on the exchanges must provide.<sup>27</sup> Also, it limits the manner in which insurers may vary premiums for different policyholders for policies sold under the exchanges.<sup>28</sup>

Additionally, Title I provides numerous consumer protections. It limits insurers' ability to deny, rescind, and non-renew coverage.<sup>29</sup> It bans lifetime and annual limits on dollars expended on essential benefits.<sup>30</sup> It requires insurers to cover certain preventive care without co-pay or cost sharing.<sup>31</sup> It requires insurers to use a standard summary of policy benefits and coverage.<sup>32</sup> It creates a state-based process

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<sup>24</sup> 42 U.S.C. § 18091 (Supp. 2010); 26 U.S.C. § 5000A (Supp. 2010) (noting that exemptions from the mandate are granted in the case of: (1) religious exemptions; (2) individuals not lawfully present in the United States; (3) incarcerated individuals; or (4) individuals who cannot afford coverage (the cost of insurance exceeds 8% of the individual's household income)). Penalties for failure to maintain coverage are phased in over three years; by 2016 the penalty will be in full effect and will equal the greater of 2.5% of an individual's taxable income, or \$695. 26 U.S.C. § 5000A (Supp. 2010).

<sup>25</sup> 26 U.S.C. § 4980H (Supp. 2010).

<sup>26</sup> 42 U.S.C. § 18031 (Supp. 2010).

<sup>27</sup> 42 U.S.C. § 18022 (Supp. 2010). However, as discussed below, at least for plan years 2014 and 2015, the Secretary allows states to individually define essential benefits.

<sup>28</sup> 42 U.S.C. § 300gg (Supp. 2010). Plans may vary premiums based on only: (1) whether the plan covers an individual or family; (2) the rating area (the geographic area of the insured, set by the state); (3) age; and (4) tobacco use. *Id.* With age and tobacco use, the increase in premium cannot exceed 3 to 1 and 1½ to 1, respectively. *Id.* No other rate varying factors are permitted. *Id.*

<sup>29</sup> 42 U.S.C. §§ 300gg-2, 300gg-3, 300gg-12 (Supp. 2010).

<sup>30</sup> 42 U.S.C. § 300gg-11 (Supp. 2010). Annual limits are banned in 2014. Until then, annual limits are regulated by the Secretary of the Department of Health and Human Services.

<sup>31</sup> 42 U.S.C. § 300gg-13 (Supp. 2010).

<sup>32</sup> 42 U.S.C. § 300gg-15 (Supp. 2010). In early February 2012, the Department of Health and Human Service promulgated new rules describing what the summary of policy benefits and coverage must include. *See Health Reform to Require Insurers to Use Plain Language in Describing Health Plan Benefits, Coverage*, U.S. DEP'T HEALTH & HUMAN SERV. (Feb. 9, 2012), <http://www.hhs.gov/news/press/2012pres/02/20120209a.html>. The summary gives prominent placement to deductibles, out-of-pocket limits, annual limits, network provider requirements, specialist referral requirements, and services not covered. A sample standard policy is available at: <http://cciio.cms.gov/resources/files/Files2/02102012/sample-completed-sbcfinal.pdf> (last visited Apr. 16, 2012).

to review unreasonable premium increases.<sup>33</sup> It imposes Medical Loss Ratios requiring insurers to direct 80% or 85% of premiums towards patient care.<sup>34</sup>

Title II contains another extremely transformative provision (one under review by the Supreme Court). Title II dramatically expands eligibility for Medicaid. In 2014, Americans earning less than 138% of the poverty line will be eligible for Medicaid.<sup>35</sup> Currently, about half of the 50 million uninsured Americans earn less than 138% of the poverty line.<sup>36</sup> Prior to reform, Medicaid eligibility requirements were complex and failed to cover many poor Americans. Indeed, until this provision takes effect, states have broad latitude in determining eligibility standards.<sup>37</sup> Tying eligibility to earning will greatly expand the number of Medicaid eligible Americans. Title II also simplifies eligibility and enrollment for the Children's Health Insurance Program (CHIP).<sup>38</sup> The Medicaid expansion along with changes to CHIP eligibility are expected to cover an additional 16 million Americans.<sup>39</sup>

Title III aims to reduce Medicare costs. It creates the Center for Medicare and Medicaid Innovation to test and implement new models of care and payment.<sup>40</sup> It creates several programs designed to link payments with patient outcomes.<sup>41</sup> It also encourages coordinated care. For example, it authorizes the creation of Accountable Care Organizations (ACOs).<sup>42</sup> ACOs are somewhat analogous to HMOs.<sup>43</sup> They are

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<sup>33</sup> 42 U.S.C. § 300gg-94 (Supp. 2010).

<sup>34</sup> 42 U.S.C. § 300gg-18 (Supp. 2010) (80% for small group and individual plans, 85% for large group plans).

<sup>35</sup> 42 U.S.C. § 1396a (Supp. 2010) (the ACA specifies 133% of the federal poverty line; however the first 5% of income is disregarded yielding a 138% threshold); *see also* Reconciliation Act § 1004; Timothy Jost, *Implementing Health Reform: Medicaid and Exchange Eligibility Determinations*, HEALTH AFFAIRS BLOG (Aug. 13, 2011), <http://healthaffairs.org/blog/2011/08/13/implementing-health-reform-medicare-and-exchange-eligibility-determinations/>.

<sup>36</sup> KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAM. FOUND., THE UNINSURED: A PRIMER 22 (Oct. 2011), *available at* <http://www.kff.org/uninsured/upload/7451-07.pdf> [hereinafter KAISER, UNINSURED].

<sup>37</sup> Andrew D. Wone, *Don't Want to Pay for Your Institutionalized Spouse? The Role of Spousal Refusal and Medicaid in Funding Long-Term Care*, 14 ELDER L.J. 485, 490 (2006).

<sup>38</sup> For an example of the complexity see Medi-Cal Flowcharts, National Health Law Program, (July 2006), *available at* [healthconsumer.org/cs041Medi-CalFlowChart.pdf](http://healthconsumer.org/cs041Medi-CalFlowChart.pdf).

<sup>39</sup> CONG. BUDGET OFFICE, SELECTED CBO PUBLICATIONS RELATED TO HEALTH CARE LEGISLATION 2009-2010 11 (2010), *available at* <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf> [hereinafter CBO PUBLICATIONS].

<sup>40</sup> 42 U.S.C. § 1315a (Supp. 2010); *The CMS Innovation Center*, CENTER FOR MEDICARE & MEDICAID INNOVATION, <http://innovations.cms.gov/index.html> (last visited Apr. 16 2012).

<sup>41</sup> 42 U.S.C. § 1395ww (Supp. 2010).

<sup>42</sup> Jenny Gold, *Accountable Care Organizations, Explained*, NPR (Jan. 18, 2011), <http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained>.

<sup>43</sup> *Id.*

organizations of hospitals and care providers jointly responsible for providing care to a group of Medicare recipients.<sup>44</sup> By coordinating care, ACOs are hoped to decrease costs.<sup>45</sup> Though reimbursed through a traditional fee-for-service system, ACOs will receive bonus for managing costs while maintaining quality benchmarks.<sup>46</sup> Title III also creates the Independent Payment Advisory Board (IPAB) to propose Medicare cuts.<sup>47</sup>

Title IV aims to improve American's health. It creates the National Prevention, Health Promotion and Public Health Council to improve prevention and public health.<sup>48</sup> It also creates more clinical preventive services.<sup>49</sup> One particularly visible provision requires restaurant chains of twenty or more restaurants to display calorie counts on the menu.<sup>50</sup>

Title V is designed to train more doctors and nurses to meet the needs of ACA's focus on primary care. It encourages health professionals to enter primary care. It provides a primary care bonus to clinicians who participate in Medicare.<sup>51</sup> And it offers scholarships and loan forgiveness for primary care physicians, nurse practitioners, and physician assistants practicing in underserved areas.<sup>52</sup>

Title VI contains numerous provisions designed to crack down on Medicare and Medicaid fraud. It targets care providers, nursing homes, long-term facilities, and Medicare and Medicaid providers.<sup>53</sup>

Title VII implements changes affecting the pharmaceutical industry. Primarily, it empowers the Food and Drug Administration (FDA) to approve generic versions of biologic drugs.<sup>54</sup> Biologics are treatments created by biological processes, such as vaccines, blood, and tissues.<sup>55</sup> Biologic drugs are larger, more complex molecules

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<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> 42 U.S.C. § 1395kkk (Supp. 2010).

<sup>48</sup> 42 U.S.C. § 300u-10 (Supp. 2010).

<sup>49</sup> 42 U.S.C. § 299b-4 (Supp. 2010).

<sup>50</sup> 21 U.S.C. § 343 (Supp. 2010).

<sup>51</sup> Karen Davis et al., *How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation*, 26 J. GEN. INTERNAL MED. 1201 (2011).

<sup>52</sup> *Id.* at 1202.

<sup>53</sup> See Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title VI (2010); see also U.S. DEP'T JUSTICE, <http://www.justice.gov/iso/opa/ag/speeches/2012/ag-speech-120228.html> (The Attorney General, testifying before a House Appropriations Subcommittee, suggested the potential savings in combatting healthcare fraud: "[O]ver the last three years, for every dollar we spent combating health-care fraud, we've been able to return an average of seven dollars to the U.S. Treasury, the Medicare Trust Fund, and others.").

<sup>54</sup> 42 U.S.C. § 262 (Supp. 2010).

<sup>55</sup> Maggie Mahar, *Using Medicare's Clout to Negotiate Drug Prices*, HEALTH BEAT (Apr. 15, 2011), <http://www.healthbeatblog.com/2011/04/using-medicare-clout-to-negotiate-drug-pricesdid-obama-put-that-back-on-the-table.html>.

than the “small-molecule drugs” more typically associated with prescription drugs.<sup>56</sup> Their complexity makes creating generic versions difficult.<sup>57</sup> Unlike typical prescriptions, generic versions of biologic drugs are not identical to the original, but are “biosimilars” or “follow-on biologics.”<sup>58</sup> The ACA regulates the creation and sale of biosimilars, but grants the creator of the original biologic drug a twelve-year window of exclusivity.<sup>59</sup>

Title VIII, the CLASS Act has not been implemented by the Obama administration. It would have created a voluntary disability insurance program providing cash benefits if an enrollee were to become disabled.<sup>60</sup> The Obama administration chose not to implement the CLASS Act when it was determined that adverse selection would make the premiums unaffordable.

Title IX imposes new taxes to help fund the ACA’s health care expansion. Starting in 2018, it taxes employer-provided coverage exceeding \$10,200 for individuals and \$27,500 for families (though these amounts are increased for certain factors including age).<sup>61</sup> It taxes certain medical devices.<sup>62</sup>

Title I of The Health Care and Education Reconciliation Act of 2010 changes numerous provisions of the PPACA. Perhaps most famously, it removes special provisions favoring certain states, including the “Cornhusker Kickback,” which provided unlimited federal funding for Medicaid expansion in Nebraska. The Reconciliation Act now provides equal funding for Medicaid expansion to all states.<sup>63</sup> All states and the District of Columbia will receive 100% of the cost of Medicaid expansion until 2016.<sup>64</sup>

Title I also increases subsidies to buy insurance for individuals making up to 400% of the federal poverty line.<sup>65</sup> It imposes a payroll tax on certain “unearned income.”<sup>66</sup> It closes the Medicare Part D “donut hole” by 2020.<sup>67</sup> It also reduces spending on Medicare Part C, Medicare Advantage, a government-subsidized private alternative to Medicare.

Title II increases Federal Pell Grants and terminates the Federal Family Education Loan Program (FFELP). FFELP was a costly arrangement under which

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<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> KAISER FAM. FOUND., HEALTH CARE REFORM AND THE CLASS ACT (Apr. 2010), available at [http:// www.kff.org/healthreform/upload/8069.pdf](http://www.kff.org/healthreform/upload/8069.pdf).

<sup>61</sup> 26 U.S.C. § 4980I (Supp. 2010).

<sup>62</sup> 26 U.S.C. § 4191 (Supp. 2010) (“Medical device” does not include eyeglasses, contact lenses, hearing aids, and “any other medical device determined by the Secretary to be of a type which is generally purchased by the general public at retail for individual use.”).

<sup>63</sup> 42 U.S.C. § 1396d (Supp. 2010).

<sup>64</sup> *Id.*

<sup>65</sup> 26 U.S.C. § 36B (Supp. 2010).

<sup>66</sup> 26 U.S.C. § 1411 (Supp. 2010).

<sup>67</sup> 42 U.S.C. § 1395w-102 (Supp. 2010).

banks acted as middlemen for federally-guaranteed student loans. Now, all loans come directly from the Department of Education to students.<sup>68</sup> The savings are used to fund the ACA.

*B. How the Affordable Care Act is Projected to Expand Coverage and Reduce Costs*

In evaluating individual provisions of the ACA, it is useful to consider the objectives of the ACA, as a whole. The ACA is expected to achieve near universal coverage, covering 32 million of the 50 million uninsured Americans.<sup>69</sup> Those left uninsured are expected to break down as follows: 36.5% are individuals eligible for Medicaid under the ACA, but who fail to enroll; 24.5% are undocumented immigrants, who are barred by the ACA from subsidies or Medicaid; 16.2% are those who are exempted from the mandate due to the lack of available affordable coverage; 15.3% are those not eligible for subsidized coverage, and who fail to purchase coverage deemed affordable; and 7.5% are eligible for subsidized insurance from an exchange, but who fail to purchase coverage.<sup>70</sup> But despite these expected coverage gaps, the ACA comes close to achieving near universal health care coverage.

Comparatively, the ACA cost reduction measures are less dramatic. One observer noted: “The job of figuring how to cover uninsured people used up all the political oxygen that was available . . . They didn’t have the energy for costs.”<sup>71</sup> This characterization may not be entirely fair because the ACA implements numerous provisions to reduce the cost of care.

Four actors drive up the cost of health care: (1) insurance companies; (2) pharmaceutical companies; (3) care providers; and (4) patients. While the ACA affects all of these actors, the primary focus is on insurance companies and their relationship with insureds.<sup>72</sup>

### 1. Insurance Companies

Insurance companies drive up the cost of care through administrative expenses. An estimated 7% of health care expenditures are for administrative costs including marketing and billing.<sup>73</sup> These costs are reflected in an insurer’s medical loss ratio, the ratio of premium dollars spent on patient care over the total premiums collected. As we discuss below, the ACA addresses this cost driver by requiring insurance

<sup>68</sup> 20 U.S.C. § 1071 (Supp. 2010).

<sup>69</sup> CBO PUBLICATIONS, *supra* note 39, at 11.

<sup>70</sup> MATTHEW BUETTGENS & MARK A. HALL, ROBERT WOOD JOHNSON FOUND., WHO WILL BE UNINSURED AFTER HEALTH INSURANCE REFORM? 5 (Mar. 2011), available at <http://www.rwjf.org/files/research/71998.pdf>.

<sup>71</sup> John Dorschner, *Cost Issues Remain Despite Healthcare Reforms*, MIAMI HERALD, Mar. 31, 2010, available at <http://www.healthleadersmedia.com/content/FIN-248814/Cost-issues-remain-despite-healthcare-reforms> (quoting Alan Sager).

<sup>72</sup> See David Gratzer, *Curves: The Rise and Fall of A Health Care Cover Story*, 25 NOTRE DAME J.L. ETHICS & PUB. POL’Y 363, 376 (2011) (noting “ObamaCare’s focus on insurance prices, costs, and subsidies is hardly unique. For half a century, American healthcare analysts have seen health care as an insurance problem, not a health problem”).

<sup>73</sup> Kaiser Fam. Found., *U.S. Health Care Costs*, KAISEREDU, <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx> (last visited Apr. 16, 2012).

companies to maintain a prescribed medical loss ratio. Insurance companies that fail to satisfy these new ACA requirements must refund premium dollars to their insureds.

The ACA also seeks to reduce costs by spurring competition between insurance companies. The state-based exchanges are the primary vehicle for this. Individuals and small businesses will be able to compare different plans in a single online market place—as is available to Massachusetts citizens, under Massachusetts’s enacted health care reform. It is hoped that enabling apples-to-apples comparisons will encourage insurers to reduce premiums. Additionally, exchanges have the option of selectively contracting for plans and making the plans compete on cost and benefits in order to participate.

Additionally, the ACA seeks to reduce insurance company costs (thus reducing premiums) by diversifying the pool of insured. By requiring nearly all Americans to maintain coverage, healthy Americans, who might choose to forgo coverage, will be more likely to enroll, thus reducing an insurance company’s cost for patient care.

## 2. Pharmaceutical Companies

In 1965, when Medicare was created, prescription drugs did not play as important a role as they do today—they were also more affordable.<sup>74</sup> Today, prescription drugs are a significant cost driver. The Congressional Budget Office (CBO) concluded that about half of all growth in health care spending, in the several decades preceding 2008, was associated with changes in medical care made possible by advances in technology.<sup>75</sup> Prescription drugs are a significant part of that growth.<sup>76</sup> Since the mid-1990s, spending on prescription drugs has contributed a significant portion to the growth in total spending.<sup>77</sup> From 1995 to 2005, prescription drug spending grew by an average of about 10% per year.<sup>78</sup>

The importance of pharmaceuticals in modern treatment, as well as their high development cost, has driven pharmaceutical companies to demand high prices for drugs. Retail prescription prices rose from an average price of \$38.43 in 1998 to \$71.69 in 2008.<sup>79</sup> “[T]he average brand name prescription price in 2008 was almost 4 times the average generic price (\$137.90 vs. \$35.22). Of the average retail prescription price of \$71.69, manufacturers received 78%, retailers received 17%, and wholesalers received 4% in 2008.”<sup>80</sup>

Purchasers of care (insurance companies, government agencies, and individuals) often need significant marketing clout to negotiate low prices for pharmaceuticals.

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<sup>74</sup> BARRY FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 781 (6th ed. 2008).

<sup>75</sup> CONG. BUDGET OFFICE, *TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING* 1 (Jan. 31, 2008), available at <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf> [hereinafter CBO TECHNOLOGICAL CHANGE].

<sup>76</sup> *Id.* at 4.

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> See KAISER FAM. FOUND., *PRESCRIPTION DRUG TRENDS* (May 2010), available at <http://www.kff.org/rxdrugs/upload/3057-08.pdf> [hereinafter DRUG TRENDS].

<sup>80</sup> *Id.*

Federal agencies, including the Department of Veterans Affairs, the Department of Defense, the Public Health Service, and the Coast Guard, participate in the Federal Supply Schedule to purchase drugs from manufacturers at prices equal to or lower than those charged to “most-favored” nonfederal purchasers.<sup>81</sup> But smaller insurance companies often pay far higher rates. Similarly, Medicare is prohibited from directly negotiating drug prices or rebates with manufacturers to control costs.<sup>82</sup>

Additionally, brand name drugs generally command a significant premium over generic drugs. Pharmaceutical companies often convince patients to opt for brand name drugs. Companies heavily advertise brand name drugs.<sup>83</sup> “Manufacturer spending on advertising was over 1.5 times as much in 2009 (\$10.9 billion) as in 1999 (\$6.6 billion).”<sup>84</sup> They also offer coupons and discounts to patients, such that a patient’s co-pay for a brand name prescription drug may be lower than the co-pay for a generic drug (even though the total cost of the brand name drugs is significantly higher).<sup>85</sup> Companies may also alter the brand name drug to provide a convenience benefit over the generic version.<sup>86</sup> For example, a brand name drug may only need to be taken once a day rather than twice a day for the generic drug.<sup>87</sup> These minor benefits may cause the patient or care provider (who are not likely aware of the drug’s full cost) to select the brand name drug. “New drugs can increase overall drug spending if they are used in place of older, less expensive medications; if they supplement, rather than replace existing drugs treatments; or if they treat a condition not previously treated with drug therapy.”<sup>88</sup>

Here, ACA does comparatively less to reduce costs. Brand name drug manufacturers will provide a 50% discount on brand name and biologic drugs for Medicare Part D enrollees who reach the coverage “doughnut hole.”<sup>89</sup> Manufacturers may offset these discounts, however, by raising prices charged to pharmacies or reducing rebates to insurers.<sup>90</sup> Pharmaceutical manufacturers and importers with sales exceeding \$5,000,000 will pay a combined annual flat fee ranging from \$2.5 billion to \$4.1 billion, until 2019 when the fee will remain at \$2.9

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<sup>81</sup> *Id.* at 6-7.

<sup>82</sup> *Id.* at 7.

<sup>83</sup> *See id.* at 4.

<sup>84</sup> *Id.*

<sup>85</sup> Chana Joffe-Walt, *Drug Coupons Hide True Costs From Consumers*, NPR (Oct. 20, 2009), <http://www.npr.org/templates/story/story.php?storyId=113969968>.

<sup>86</sup> *See id.*

<sup>87</sup> *See id.*

<sup>88</sup> DRUG TRENDS, *supra* note 79, at 3.

<sup>89</sup> KAISER FAM. FOUND., EXPLAINING HEALTH CARE REFORM: KEY CHANGES TO THE MEDICARE PART D DRUG BENEFIT COVERAGE GAP (Mar. 2010), *available at* <http://www.kff.org/healthreform/upload/8059.pdf>.

<sup>90</sup> Letter from Douglas W. Elmendorf, Director Congressional Budget Office, to Paul Ryan, Ranking Member Committee on the Budget U.S. Senate (Nov. 4, 2010), *available at* [http://www.cbo.gov/ftpdocs/116xx/doc11674/11-04-Drug\\_Pricing.pdf](http://www.cbo.gov/ftpdocs/116xx/doc11674/11-04-Drug_Pricing.pdf) [hereinafter Ryan Letter].

billion.<sup>91</sup> Although the Congressional Budget Office projects this fee will “probably” increase the price of drugs purchased through Medicaid and other federal programs by about 1%.<sup>92</sup> Additionally, the Medicare Independent Payment Advisory Board may propose cost reductions aimed at reducing Medicare expenditures on prescription drugs.

Still, pharmaceuticals themselves can be a significant cost container. It is often cheaper to treat patients with prescription drugs rather than surgical procedures.<sup>93</sup>

### 3. Care Providers

Similarly, care providers including doctors, hospitals, and other medical professionals increase the cost of care. Some increases are unrelated to market forces. Historically, the most significant driver in healthcare costs has been the development of effective medical treatments.<sup>94</sup> In the early twentieth century, the dearth of efficacious treatments for illnesses kept the cost of care low.<sup>95</sup> Today, with care providers providing essential services, costs have inevitably risen. Market forces also affect the cost of care. As with prescription drugs, a care payer must have significant buying power to negotiate lower rates for care. Indeed, hospitals often charge varying rates for procedures. The highest rates are paid by those paying out of pocket; the lowest rates are often paid by large insurance companies.

While the ACA seeks to spur competition among insurers (largely through insurance exchanges) to drive down costs, the ACA does little to help insurers negotiate rates with care providers. Thus, increased competition among insurance companies may not result in lower costs for consumers. The increased competition may cause insurance companies to become more efficient in terms of reducing overhead and other non-care expenses. But a large, more monopolistic insurance company is more likely to be able to negotiate lower rates than many smaller competing insurance companies.

Indeed, in the mid-to-late 1990s, hospitals consolidated at a record rate.<sup>96</sup> Thus, fewer hospital systems dominated many major metropolitan areas.<sup>97</sup> These large providers could demand higher rates for services from care payers, such as insurance companies.<sup>98</sup>

One potential solution not addressed by the ACA is regulating the rates that care providers may charge per-procedure. In Maryland, the Maryland Health Services Cost Review Commission sets rates for procedures for all care purchasers including

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<sup>91</sup> Patient Protection and Affordable Care Act, Pub. L. 111-148, § 9008, 124 Stat. 119, 859 (2010).

<sup>92</sup> RYAN LETTER, *supra* note 90.

<sup>93</sup> See DRUG TRENDS, *supra* note 79, at 1.

<sup>94</sup> Eleanor D. Kinney, *For Profit Enterprise in Health Care: Can it Contribute to Health Reform?*, 36 AM. J. L. & MED. 405, 414 (2010).

<sup>95</sup> *Id.*

<sup>96</sup> PRICE WATERHOUSE COOPERS, THE FACTORS FUELING RISING HEALTHCARE COSTS 5 (2002), available at <http://www.ahipresearch.org/pdfs/PwCFinalReport.pdf>.

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*



Medicare, Medicaid, private insurers, and out-of-pocket payers.<sup>99</sup> It “stops hospitals from shifting billions in costs to the employers that pay insurance premiums. The cost of uncompensated care for the poor is borne by everybody, not just urban hospitals.”<sup>100</sup> “When the program began in 1977, the state’s hospital costs were 25% higher than the national average. [In early 2010], Maryland’s hospital costs [were] 2% lower than the national average.”<sup>101</sup>

But this may not be a complete answer. “If fees are lowered, physicians could compensate by trying to make up the difference with a higher volume of services. Indeed, that is what has happened in Japan, where patients are more likely to see doctors and receive MRI or CT scans than in the U.S.”<sup>102</sup> Still, the cost of a MRI in Japan is \$160; in the United States, it is closer to \$1,700.<sup>103</sup>

One area where the ACA stands to reduce costs is by altering fee-for-service arrangements. Care providers increase cost by virtue of their reimbursement mechanism. Most care providers are paid on a fee-for-service basis. The more procedures performed, the more a provider is paid—regardless of patient outcome. This can incentivize unnecessary care and financially penalizes care providers who coordinate care and keep patients healthy and avoid hospitalization.<sup>104</sup> Moreover, this combines with the incentive to run more tests to guard against lawsuits or to ensure the patient receives the best possible care or both. Indeed, “what one provider may consider to be defensive medicine may be deemed prudent medicine by another.”<sup>105</sup>

The ACA addresses this concern in part largely through changes in Medicare. It creates the Center for Medicare and Medicaid Innovation to test and implement new models of care and payment.<sup>106</sup> It also incentivizes good patient outcomes though

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<sup>99</sup> Jay Hancock, *Will New Regulators Slow Progress on Hospital Costs?*, BALTIMORE SUN, July 17, 2011, available at [http://articles.baltimoresun.com/2011-07-17/health/bs-bz-hancock-health-care-inflation-20110717\\_1\\_health-care-maryland-hospital-association-cost-commission](http://articles.baltimoresun.com/2011-07-17/health/bs-bz-hancock-health-care-inflation-20110717_1_health-care-maryland-hospital-association-cost-commission).

<sup>100</sup> *Id.*

<sup>101</sup> Maggie Mahar, *Massachusetts’ Problem and Maryland’s Solution We Don’t Have to Wait for Washington Part 2*, HEALTH BEAT (Feb. 5, 2010), <http://www.healthbeatblog.com/2010/02/massachusetts-problem-and-marylands-solution-we-dont-have-to-wait-for-washington-part-2-.html>.

<sup>102</sup> David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FIU L. REV. 67, 77 (2010).

<sup>103</sup> Chana Joffe-Walt, *In Japan, MRIs Cost Less*, NPR (Nov. 18, 2009), <http://www.npr.org/templates/story/story.php?storyId=120545569>.

<sup>104</sup> See CTR. FOR MEDICARE & MEDICAID INNOVATION, ONE YEAR OF INNOVATION: TAKING ACTION TO IMPROVE CARE AND REDUCE COSTS 2 (2012), available at <http://innovations.cms.gov/Files/reports/Innovation-Center-Year-One-Summary-document.pdf>.

<sup>105</sup> CBO TECHNOLOGICAL CHANGE, *supra* note 75, at 11.

<sup>106</sup> 42 U.S.C. § 1315a (Supp. 2010); see also CTR FOR MEDICARE & MEDICAID INNOVATION, <http://innovations.cms.gov/index.html> (last visited Apr. 16, 2012).

ACOs.<sup>107</sup> It is hoped that if these smaller programs are successful they may be more widely adopted.

#### 4. Patients

Finally, individual patients are large drivers of costs. Patients want the best possible care and the type of care can sometimes be the difference between life or death. Indeed, rising personal income leads to higher spending on health care, because patients naturally demand more care as their income rises.<sup>108</sup> “A relatively high per capita income in the United States . . . is often cited by economists as explaining a large part of the difference in per capita health spending between the United States and other developed nations.”<sup>109</sup> At the same time, patients with insurance rarely know the actual cost of care when choosing a course of care.

Some have analogized this system to a hypothetical food insurance system where food is provided through insurance just as health care is.<sup>110</sup> An insured would go to a supermarket and be admitted by paying a small co-pay.<sup>111</sup> None of the store items would have prices on them, and the insured could take whatever he wished—lobster, filet mignon, *foie gras*.<sup>112</sup> Without knowing what the items cost, the insureds unknowingly drive up the overall cost of care.<sup>113</sup>

This analogy, however, is not perfect. Patients do not stroll through pharmacies grabbing every appealing drug, nor do they peruse hospital departments to consider attractive procedures. Rather, drugs and procedures are selected by trained medical experts based on the patient’s needs. But, in deciding on an appropriate course of care, often neither the patient nor the doctor knows the actual cost of the care.

For the patient, the question of care is generally, should I get the care or not, not what level of care provides the best cost-benefit ratio. Arguably, in questions of life or death, cost-benefit is irrelevant. But with many end of life procedures, the question is not life or death so much as, undergo this expensive and invasive procedure and live a little longer, or forgo the procedure and die sooner, but perhaps more comfortably. These decisions can be expensive. Indeed, in 2009, Medicare paid \$50 billion for care during the last two months of patients’ lives.<sup>114</sup>

These difficult questions become even more complicated when the decision involves a patient who is incapable of making an informed decision. Often family members must make decisions on end-of-life care without knowing the ailing family member’s wishes.

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<sup>107</sup> Jenny Gold, *Accountable Care Organizations, Explained*, NPR (Jan. 18, 2011), <http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained>.

<sup>108</sup> CBO TECHNOLOGICAL CHANGE, *supra* note 75, at 9.

<sup>109</sup> *Id.*

<sup>110</sup> *This American Life: Someone Else’s Money*, CHICAGO PUB. RADIO (Oct. 16 2009), <http://www.thisamericanlife.org/radio-archives/episode/392/transcript>.

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *60 Minutes: The Cost of Dying*, CBSNEWS.COM (Dec. 3, 2010), <http://www.cbsnews.com/stories/2009/11/19/60minutes/main5711689.shtml>.

The ACA attempted to address difficult questions of end-of-life care by funding end-of-life counseling whereby Medicare enrollees could meet with their care providers to discuss their wishes should they become unable to decide for themselves.<sup>115</sup> This provision was unfairly characterized as a “death panel” and was removed from the ACA.<sup>116</sup> However, in December 2010, the Obama administration has implemented this provision through Medicare regulation.<sup>117</sup>

Additionally, the overall health of Americans can affect the cost of care. Dr. David Gratzer, notes that if “America slashed its rate of obesity-related illness by 20% in the next five years . . . America’s care system could save \$30 billion or more annually, forever.”<sup>118</sup> Similarly, “Congress could save \$20 billion annually simply by ending subsidies for unhealthy food ingredients. Either step would save more in ten years than the best projected savings for ObamaCare.”<sup>119</sup>

The ACA does attempt to reduce costs by making Americans healthier. It includes a provision that requires chain restaurants to disclose calorie counts in menu items.<sup>120</sup> It also funds programs aimed at reducing smoking and encourages healthier lifestyles.<sup>121</sup>

More can be done to reduce the cost of care, but the ACA makes great strides in reducing costs. This is in addition to the massive expansion of coverage that the ACA is expected to generate. These improvements are implemented over the course of five years. By January 20, 2013, the earliest likely time of repeal, many important provisions will have taken effect.

Below, we evaluate significant individual provisions of the ACA to determine the consequences of repeal in 2013. We consider which provisions have enabled Americans to obtain coverage and how repeal would affect them. We similarly evaluate the loss of consumer protections afforded by the ACA. We also evaluate the provisions that have garnered significant implementation effort and expense. We first consider these provisions independently and then as a whole in our conclusion. We divide these provisions into four categories: (1) consumer protections; (2) changes to the private health care market; (3) changes to Medicare; and (4) taxes and costs savings.

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<sup>115</sup> Robert Pear, *Obama Returns to End-of-Life Plan That Caused Stir*, N.Y. TIMES, Dec. 25, 2010, available at <http://www.nytimes.com/2010/12/26/us/politics/26death.html>.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> David Gratzer, *Curves: The Rise and Fall of A Health Care Cover Story*, 25 NOTRE DAME J.L. ETHICS & PUB. POL’Y 363, 378 (2011).

<sup>119</sup> *Id.*

<sup>120</sup> 21 U.S.C. § 343 (Supp. 2010).

<sup>121</sup> Interestingly, Section 10101 of the Affordable Care Act, which implements wellness and health promotion activities, includes a provision entitled “Protection of Second Amendment Gun Rights.” This provision prohibits a wellness program from requiring the disclosure or collection of information relating to an individual’s use or ownership of firearms.

## IV. SIGNIFICANT AFFORDABLE CARE ACT PROVISIONS AFFECTED BY REPEAL

## A. Consumer Protections

## 1. Ban on Lifetime and Annual Limits

On September 23, 2010—six months after the ACA was signed—the provision banning lifetime limits on essential health benefits took effect.<sup>122</sup> A sister provision, banning annual limits for essential benefits, will take effect on January 1, 2014.<sup>123</sup> But prior to 2014, the ACA restricts many insurers' ability to impose annual limits on essential benefits.<sup>124</sup> These restrictions are imposed through regulations promulgated by the Department of Health and Human Services (HHS).<sup>125</sup>

The ban on lifetime limits applies to group and individual plans with plan years beginning after September 23, 2010. The lifetime limit applies to essential benefits; insurers may still cap spending for care not included within defined essential benefits.<sup>126</sup> Essential health benefits are the services that qualified health plans, which offer coverage through Exchanges, as well as all non-grandfathered plans in the individual and small group markets, must cover as part of their benefit package.<sup>127</sup>

Although it was originally assumed that a federal standard would define essential benefits, in mid-December 2011, the Department of Health and Human Services announced that it would not provide a uniform set of essential health benefits, but

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<sup>122</sup> 42 U.S.C. § 300gg-11(a) (Supp. 2010); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1004, 124 Stat. 119 (2010).

<sup>123</sup> 42 U.S.C. § 300gg-11(a) (Supp. 2010).

<sup>124</sup> *Id.*

<sup>125</sup> For plan years beginning on or after September 23, 2010, but before September 23, 2011, the annual limit may not be below \$750,000. 45 C.F.R. § 147.126(d) (2012). For plan years beginning on or after September 23, 2011, but before September 23, 2012, the annual limit may not be below \$1,250,000. *Id.* For plan years beginning on or after September 23, 2012, but before January 1, 2014, the annual limit may not be below \$2,000,000. *Id.* And beginning in plan year 2014, annual limits on essential health benefits will be eliminated entirely. 42 U.S.C. § 300gg-11(a) (Supp. 2010).

<sup>126</sup> *Lifetime & Annual Limits*, HEALTHCARE.GOV (Sept. 23, 2010), <http://www.healthcare.gov/law/features/costs/limits/index.html>.

<sup>127</sup> 42 U.S.C. § 18022 (Supp. 2010) (The ACA specifies: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.). These essential health benefits are defined broadly in the ACA, but they have yet to be determined with specificity in regulations promulgated by the Department of Health and Human Services. The Institute of Medicine has issued a lengthy advisory report on methodologies for determining the scope of essential health benefits, however. *See* INST. OF MED., *ESSENTIAL HEALTH BENEFITS: BALANCING BENEFITS AND COSTS* (2012).

instead would allow states to define required benefits.<sup>128</sup> Under the new proposal, essential benefits would be defined by a benchmark plan selected by each State.<sup>129</sup> This approach would mirror one used to define benefits for the Children's Health Insurance Program (CHIP) plans.<sup>130</sup> States may choose as their benchmark plan:

- (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national FEHBP plan options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.<sup>131</sup>

If a state does not select a benchmark plan, the Department will select a default plan, likely the largest plan by enrollment in the largest product in the State's small group market.<sup>132</sup> Thus essential benefits will likely vary from state to state.<sup>133</sup> But for years following 2015, the Department will reevaluate the definition of essential benefits and may issue a uniform federal standard.

The new restrictions on annual limits, however, do not apply to all plans. Grandfathered plans (non-employer issued group or individual plans in which the insured enrolled on or before March 23, 2010) are exempt.<sup>134</sup> And the Health and Human Services Secretary may issue waivers of this requirement for plans where compliance would "result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage."<sup>135</sup> Plans receiving waivers have included limited benefit or "mini-med" plans, inexpensive plans generally providing limited

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<sup>128</sup> Press Release, Dep't Health & Human Serv., HHS to Give States More Flexibility to Implement Health Reform (Dec. 16, 2011), *available at* [http://www.hhs.gov/news/press/2011pres/12/2011\\_1216c.html](http://www.hhs.gov/news/press/2011pres/12/2011_1216c.html).

<sup>129</sup> CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN, 8 (Dec. 16, 2011), *available at* [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).

<sup>130</sup> *Id.*

<sup>131</sup> *Id.* at 9.

<sup>132</sup> *Id.*

<sup>133</sup> One might wonder how plans may comply with existing annual limit restrictions while essential benefits have not yet been defined. The Department of Health and Human Services explains: "For plan years (in the individual market, policy years) beginning before the issuance of regulations defining 'essential health benefits,' for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term 'essential health benefits.'" Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37,188-01, 37,191 (June 28, 2010) (to be codified at 45 C.F.R. pt. 144, 146-47).

<sup>134</sup> 42 U.S.C. § 18011 (Supp. 2010).

<sup>135</sup> 45 C.F.R. § 147.126 (2012).

coverage.<sup>136</sup> In June of 2011, though, the HHS announced it would stop accepting applications for annual limit waivers in September of 2011.<sup>137</sup>

Prior to this provision taking effect, many health insurance policies limited the dollar amount of covered claims in a given plan year or during the enrollee's lifetime. The HHS estimated that, when the ACA was signed, 105 million Americans had coverage with a lifetime limit: 70 million through large employer plans; 25 million through small employer plans; and 10 through individual policies.<sup>138</sup>

Enrollees that reach a limit are effectively uninsured and face the same problems as the uninsured. They do not get regular care, they rely on emergency rooms for treatment, or they go bankrupt trying to pay their claims. And typically a person reaches the limit because she is already seriously ill and requires expensive treatment. With lifetime and annual limits, those who need care the most are cut off either for the year or for the rest of their life. This means more uncompensated care, more medical bankruptcies, and more poor health. About 75% of uncompensated care (in 2008 \$42.9 billion of the \$57 billion total) is paid by federal, state, and local funds.<sup>139</sup>

Now, under this provision, many insured Americans will have significantly more robust protection, so long as they only require care determined important enough to be included in Exchange-based coverage.

However, this protection is not airtight. Annual limits, though set very high by HHS regulations, can be reached. For example, treatment of colon cancer can exceed \$200,000 and treatment of other advanced stage cancers can exceed \$1,000,000. One or more costly diseases can cause an insured to reach an annual limit. Indeed, several types of organ transplants may easily cost upwards of \$1,000,000 as well.<sup>140</sup>

Individuals covered by plans receiving a waiver of this provision can easily reach their significantly lower limits. McDonalds Corporation, for example, received a waiver for its plans capping annual payouts at \$2,000 or \$10,000.<sup>141</sup> Thus

<sup>136</sup> *Annual Limits*, CTR FOR CONSUMER INFO. & INS. OVERSIGHT, <http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html> (last visited Apr. 16, 2012).

<sup>137</sup> Robert Pear, *Program Offering Waivers for Health Law is Ending*, N.Y. TIMES, June 17, 2011, available at [http://www.nytimes.com/2011/06/18/health/policy/18health.html?\\_r=2&scp=1&sq=health%20law&st=cse](http://www.nytimes.com/2011/06/18/health/policy/18health.html?_r=2&scp=1&sq=health%20law&st=cse).

<sup>138</sup> THOMAS D. MUSCO & BENJAMIN D. SOMMERS, U.S. DEP'T OF HEALTH & HUMAN SERV. UNDER THE AFFORDABLE CARE ACT, 105 MILLION AMERICANS NO LONGER FACE LIFETIME LIMITS ON HEALTH BENEFITS 1 (2012), available at <http://aspe.hhs.gov/health/reports/2012/LifetimeLimits/ib.pdf>.

<sup>139</sup> KAISER, UNINSURED, *supra* note 36, at 14.

<sup>140</sup> See T. SCOTT BENTLEY ET AL., MILLIIMAN, 2011 U.S. ORGAN AND TISSUE TRANSPLANT COST ESTIMATES AND DISCUSSION 4 (2011), available at <http://publications.milliman.com/research/health-rr/pdfs/2011-us-organ-tissue.pdf> (total average cost of a heart transplant: \$997,700; intestine: \$1,206,800; and various multi-organ transplants: over \$1,000,000).

<sup>141</sup> See Janet Adamy, *McDonald's May Drop Health Plan*, WALL ST. J., Sept. 30, 2010, available at <http://online.wsj.com/article/SB10001424052748703431604575522413101063070.html>.

until 2014, many Americans who are most at risk of reaching an annual limit may not be protected by this provision.

A 2013 repeal of the ACA and the accompanying loss of this provision would be significant. Many insured Americans would likely see their policy's annual limit drop from \$1,250,000 to something much lower. And a lifetime limit would likely reappear on the policy. However, given the exception for grandfathered clauses and the 1,472 waivers<sup>142</sup> granted (as of August 19, 2011) to plans covering at least 3.2 million individuals,<sup>143</sup> the loss of this provision in 2013 would be slightly less dramatic than it would be in 2014, when the annual limit restrictions apply to all plans. Nevertheless, the loss of this provision would be significant and would likely affect many of the sickest Americans with the least options to pay for continued treatment.

## 2. The Extension of Dependent Coverage

On September 23, 2010—six months after the ACA's enactment—the extension of dependent coverage provision took effect.<sup>144</sup> It requires insurers offering group or individual health plans that cover dependent children to continue to offer coverage until the adult child turns twenty-six years old.<sup>145</sup> Insurers may not charge different rates for children under twenty-six; twenty-five year-old dependents cannot be charged more than sixteen year-olds on the same plan.<sup>146</sup> But insurers may charge more to add a dependent if the plan's cost is based on a self-plus system.<sup>147</sup>

Dependent children under twenty-six who lost their coverage due to age, prior to ACA, must be given a thirty-day opportunity (with written notice) to enroll starting the first day of the first plan year following September 23, 2010.<sup>148</sup>

Limited exclusions apply. Grandchildren (the children of dependent children) are not included.<sup>149</sup> Plans that do not provide dependent coverage are not under the ambit of this provision.<sup>150</sup> And "grandfathered" group plans (including most plans that existed on March 23, 2010) need not offer dependent coverage up to age twenty-six if the young adult is eligible for group coverage outside their parent's plan, such

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<sup>142</sup> Sam Baker, *HHS Grants 106 New Healthcare Waivers*, THE HILL (Aug. 19, 2011, 4:33 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/177581-hhs-grants-106-new-healthcare-waivers>.

<sup>143</sup> Pear, *supra* note 137.

<sup>144</sup> 42 U.S.C. § 300gg-11 credits (Supp. 2010) (making this provision, among others, operational six months after the signing of the ACA).

<sup>145</sup> 42 U.S.C. § 300gg-14 (Supp. 2010) ("[A] group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age.").

<sup>146</sup> 26 C.F.R. § 54.9815-2714T (2010).

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> 42 U.S.C. § 300gg-14 (Supp. 2010).

<sup>150</sup> B.E. WITKIN, SUMMARY OF CAL. LAW, INS. § 122C (10th ed. 2011).

as if the dependent's employer offers coverage.<sup>151</sup> However, that exception expires in 2014.<sup>152</sup>

Prior to the ACA's extension of dependent coverage, few states mandated extending coverage for children over the age of 19.<sup>153</sup> States that did, often covered only a few more years, and imposed numerous exemptions.<sup>154</sup> And prior to the ACA, eighteen to twenty-four year-olds were the least insured age group in the country.<sup>155</sup>

The extension of dependent coverage has dramatically increased the number of insured adults under twenty-six.<sup>156</sup> Three surveys have found that by the first half of 2011, 900,000 fewer adults aged nineteen to twenty-five were uninsured.<sup>157</sup> And in December of 2011, the National Center for Health Statistics released a report showing that 2.5 million Americans gained coverage under this provision.<sup>158</sup>

A full repeal of ACA would empower insurers to remove these newly covered adults. Insurers could (in accordance with state insurance laws<sup>159</sup> and individual policies) nonrenew coverage at the end of the policy year for dependent adults. And with the additional repeal of the prohibition on rescission (discussed below), insurers could rescind coverage of dependent adults if a policy application contained a mistake. Also, even if insurers allow those who gained coverage under this provision to stay on their parents plans until their twenty-sixth birthday, in many states, insurers would have no obligation to allow those newly turning eighteen to enroll or keep coverage.

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<sup>151</sup> 26 C.F.R. § 54.9815-2714T (2010).

<sup>152</sup> *Id.*

<sup>153</sup> YOUNG INVINCIBLES, IMPLEMENTING THE AFFORDABLE CARE ACT FOR YOUNG INVINCIBLES: A STATE GUIDE TO HEALTH CARE REFORM THAT WORKS FOR MILLENNIALS 3 (Nov. 2011), available at [http://www.younginvincibles.org/News/Releases/state\\_implementation\\_brief11042011.pdf](http://www.younginvincibles.org/News/Releases/state_implementation_brief11042011.pdf).

<sup>154</sup> *Id.*

<sup>155</sup> Kevin Sack, *Young Adults Make Gains in Health Insurance Coverage*, N.Y. TIMES, Sept. 21, 2011, available at <http://www.nytimes.com/2011/09/22/us/young-adults-make-gains-in-health-insurance-coverage.html>.

<sup>156</sup> *Id.*; see also *Health Insurance Coverage of Young Adults Increased Due to ACA*, CDC Reports, WOLTERS KLUWER (Oct. 3, 2011), <http://hr.cch.com/news/benefits/100311.asp>.

<sup>157</sup> Sack, *supra* note 155 ("Three new surveys, including two released on Wednesday, show that adults under 26 made significant and unique gains in insurance coverage in 2010 and the first half of 2011. One of them, by the Centers for Disease Control and Prevention, estimates that in the first quarter of 2011 there were 900,000 fewer uninsured adults in the 19-to-25 age bracket than in 2010.").

<sup>158</sup> Benjamin D. Sommers & Karyn Schwartz, *2.5 Million Young Adults Gain Health Insurance Due to the Affordable Care Act*, U.S. DEP'T. HEALTH & HUMAN SERV. (Dec. 2011), <http://aspe.hhs.gov/health/reports/2011/YoungAdultsACA/ib.pdf>.

<sup>159</sup> See, e.g., CAL. INS. CODE § 10277(f)(1) (West 2012). California, for example, amended its insurance code to conform with this provision of the ACA: "under no circumstances shall the limiting age under a group or individual health insurance policy that provides coverage of a dependent child be less than 26 years of age with respect to policy years beginning on or after September 23, 2010."



A repeal would not likely completely undo the gains from this provision. Some states, such as California, have amended their insurance laws to conform to this provision or provided somewhat comparable protections.<sup>160</sup> Moreover, adults under twenty-six are a relatively healthy group and insurance companies may not jump to remove them. Still, a repeal of the ACA would likely incentivize insurers to “cherry-pick and lemon-drop” insureds as allowed by law.

Furthermore, although this provision has been extremely popular, there is evidence that insurance companies are less enthusiastic about the provision. For example, the Reconciliation Act amended the original Reform bill to exempt grandfathered insurance plans from offering expanded dependent coverage if the adult child was eligible for an employer-sponsored health plan. That this exemption was included in the Reconciliation Act suggests that insurance companies wanted some measure of relief from this provision. Thus it is reasonable to assume that a loss of this provision would cause some dependent adults to lose coverage—particularly those with potential to require expensive future care.

2.5 million Americans have gained coverage under this provision. If the ACA is repealed, the sickest and most vulnerable among them could lose coverage. Because of the large number of Americans who have gained coverage, if even a small percentage of those who gained coverage under this provision were to lose coverage, the loss could be significant. By way of comparison, 700,000 Americans lost health coverage from 2007 to 2008 during the financial crises.<sup>161</sup>

### 3. Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status for Individuals Under Nineteen Years of Age.

Like the extension of dependent coverage provision, the prohibition of preexisting condition exclusions became effective on September 23, 2010.<sup>162</sup> This provision applies to issuers offering group or individual health insurance coverage.<sup>163</sup> It also applies to insurers that offer child-only coverage.<sup>164</sup> The provision applies to plan years following September 23, 2010.<sup>165</sup>

<sup>160</sup> *See id.*

<sup>161</sup> Karen Davenport, *Census Losses in Health Coverage Make Reform More Urgent*, CTR. FOR AM. PROGRESS (Sept. 10, 2009), [http://www.americanprogress.org/issues/2009/09/census\\_health.html](http://www.americanprogress.org/issues/2009/09/census_health.html).

<sup>162</sup> 42 U.S.C. § 300gg-11 note (Supp. 2010).

<sup>163</sup> *Id.* at § 300gg-3(a)(1).

<sup>164</sup> *See Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions*, CTRS. FOR MEDICARE & MEDICAID SERV. (Oct. 13, 2010), <http://cciiio.hhs.gov/resources/files/factsheet.html> [hereinafter *Questions and Answers on Enrollment of Children Under 19*]; *see also* Julie Rovner, *Health Insurers Skirt New Coverage Requirement For Kids*, NPR (Sept. 21, 2010, 9:04 AM), <http://www.npr.org/blogs/health/2010/09/21/130013723/colorado-insurers-skirt-new-coverage-requirement-for-kids> (some insurers are circumventing this prohibition, by dropping children-only coverage prior to enforcement of this provision).

<sup>165</sup> Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) § 2709 (“[T]he provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.”).

Under this provision, affected insurers may not exclude children under nineteen from coverage based on a preexisting condition.<sup>166</sup> The “preexisting condition” includes any condition present before the date of enrollment.<sup>167</sup> In 2014, this protection will extend to adults.<sup>168</sup> Such extension is important as many Americans have preexisting conditions. 86% of Americans in the fifty-five to sixty-four age group have a preexisting condition.<sup>169</sup>

Some insurers have challenged this provision, suggesting the requirement could lead to adverse selection.<sup>170</sup> Children (or more likely their parents) could choose not to purchase insurance while healthy and wait until they develop a condition requiring treatment.<sup>171</sup> Under this provision, the child could still obtain coverage despite the preexisting condition. This practice would increase coverage costs, as insurers would likely lose money on the children who needed extensive treatment, while lacking a healthy pool of insured children to offset the medical loss of those needing care.

Still, insurers have several means to combat adverse selection. Insurers may restrict enrollment to specific open enrollment periods.<sup>172</sup> For example, a child not enrolled in January of a certain year, may not enroll until January of the next year. Insurers may also adjust premiums based on health status as permitted by State law.<sup>173</sup> But starting in 2014, the ACA will prohibit health status rating for all new insurance plans.<sup>174</sup> Insurers may also charge more for child-only plans.<sup>175</sup> And insurers may impose a surcharge for dropping coverage and subsequently reapplying—if permitted by State law.<sup>176</sup> Insurers may institute rules to prevent dumping by employers to the extent permitted by State law.<sup>177</sup> Insurers may cease to

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<sup>166</sup> 42 U.S.C. § 300gg-3(a) (Supp. 2010) (“A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”).

<sup>167</sup> 42 U.S.C. § 300gg-3(b)(1)(A) (Supp. 2010).

<sup>168</sup> See 42 U.S.C. §§ 300gg note - 300gg-1 note (Supp. 2010).

<sup>169</sup> *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/resources/reports/preexisting.html> (last visited Apr. 16, 2012). Individuals who lack insurance in that age group have trouble obtaining coverage because of their preexisting conditions, and live without adequate care until they are eligible for Medicare. *Id.* At that point, they drive up Medicare costs because they are in poor health and consume a lot of medical services. *Id.*

<sup>170</sup> *Questions and Answers on Enrollment of Children Under 19*, *supra* note 164.

<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> See *id.*

<sup>174</sup> Patient Protection & Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 § 1255 (2010) (setting 2014 effective date); see also 42 U.S.C. § 300gg-1 (Supp. 2010).

<sup>175</sup> See *Questions and Answers on Enrollment of Children Under 19*, *supra* note 164.

<sup>176</sup> See *id.*

<sup>177</sup> *Id.*

issue child-only policies—if permitted by state law.<sup>178</sup> Or insurers may choose to sell child-only policies that are self-sustaining and separate from closed child-only books of business if permitted by State law.

Charging higher premiums based on health status to combat adverse selection may have significant consequences. If insureds cannot afford coverage there is little practical distinction between that and denying coverage based on a preexisting condition.

If the ACA were repealed, children under nineteen with preexisting conditions who obtained coverage under this provision would not likely be dramatically affected. Prior to this provision taking effect, some state laws required guaranteed issue for child-only policies.<sup>179</sup> ACA does not preempt those laws.<sup>180</sup> Also, under federal and state laws pre-dating the ACA, all child-only policies in the individual health insurance market are guaranteed renewable.<sup>181</sup> But insurers could rescind policies in certain circumstances.

And prior to this provision, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) limited group health insurers' ability to impose preexisting condition exclusions.<sup>182</sup> HIPAA only permitted such exclusions where they related to a physical or mental condition that medical care or advice was recommended or received within the six months prior to the enrollment date.<sup>183</sup> And the exclusion could only last for twelve months (or eighteen months in limited circumstances).<sup>184</sup> This was further limited if the enrollee was previously insured.<sup>185</sup>

Thus, repeal of the prohibition of discrimination based on preexisting conditions for individuals under nineteen would likely have a more symbolic rather than a practical effect. Currently, insurers have many options to avoid this provision or minimize its effect—such as charging high premiums for children with preexisting conditions. Moreover, the new provisions in many ways duplicate existing protections. However, the planned expansions of this protection to all Americans in 2014—along with restrictions on charging more for preexisting conditions—will be a dramatic change. The loss of that expansion would be significant.

#### 4. Prohibition on Rescission

Along with the above ACA provisions, the prohibition on rescission took effect on September 23, 2010.<sup>186</sup> It prohibits insurers from rescinding coverage (also

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<sup>178</sup> *Id.*

<sup>179</sup> *Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals)*, HENRY J. KAISER FAM. FOUND. (2011), <http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=353> (providing a list of states with special rules for child-only policies).

<sup>180</sup> See 42 U.S.C. § 18041(d) (Supp. 2010) (“Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.”).

<sup>181</sup> *Questions and Answers on Enrollment of Children Under 19*, *supra* note 164.

<sup>182</sup> See 29 U.S.C. § 1181 (2006).

<sup>183</sup> 29 U.S.C. § 1181(a)(1) (2006).

<sup>184</sup> 29 U.S.C. § 1181(a)(2) (2006).

<sup>185</sup> See 29 U.S.C. § 1181(a)(3) (2006).

<sup>186</sup> 42 U.S.C. § 300gg note (Supp. 2010).

known as “post claims underwriting”) after enrollment except in limited circumstances.<sup>187</sup> Prior to the ACA, rescission was a significant threat to Americans who purchased insurance on the open market; those covered by employers are generally protected from rescission by virtue of “guaranteed issue” requirements for group policies.

The protection against rescission applies to anyone enrolled in individual or group coverage with a plan or policy year beginning on or after September 23, 2010.<sup>188</sup> It also applies to all grandfathered health plans.<sup>189</sup>

Rescission is only permitted in limited circumstances: (1) where the insured has obtained coverage by fraud or has intentionally misrepresented a material fact as prohibited by the terms of the coverage;<sup>190</sup> (2) where the insured fails to timely pay premiums;<sup>191</sup> (3) where the issuer ceases to offer coverage in the individual market;<sup>192</sup> (4) where the insured no longer resides, lives, or works in the service area;<sup>193</sup> or (5) where the coverage is offered through an association, and the insured ceases to be a member of the organization.<sup>194</sup> Insurers must give at least thirty days notice before rescinding coverage to give time to appeal or find new coverage.<sup>195</sup>

Prior to the prohibition on rescission, insurers routinely scrutinized policy applications of insureds who needed expensive care to attempt to rescind coverage. Between 2003 and 2007 three insurance companies together rescinded at least 19,776 policies.<sup>196</sup> And “[b]etween 2004 and 2008, insurers rescinded 1,464 health policies or certificates based on conditions that were not diagnosed before the insureds applied for coverage.”<sup>197</sup> A National Association of Insurance Commissioners (NAIC) study of forty-six insurance companies covering about 70% of individuals covered by individual major medical policies during the period studied, found the insurers had rescinded 27,246 of 6.7 million health policies issued during the period study.<sup>198</sup> 3.7 policies were rescinded for every 1,000 policies or

<sup>187</sup> 42 U.S.C. § 300gg-12 (Supp. 2010).

<sup>188</sup> 42 U.S.C. § 300gg note (Supp. 2010).

<sup>189</sup> See 42 U.S.C. § 300gg-12 (Supp. 2010).

<sup>190</sup> *Id.*

<sup>191</sup> 42 U.S.C. § 300gg-42(b)(1) (Supp. 2010).

<sup>192</sup> 42 U.S.C. § 300gg-42(b)(3) (Supp. 2010).

<sup>193</sup> 42 U.S.C. § 300gg-42(b)(4) (Supp. 2010).

<sup>194</sup> 42 U.S.C. § 300gg-42(b)(5) (Supp. 2010).

<sup>195</sup> 26 C.F.R. § 54.9815-2712T (this section expires on June 21, 2013).

<sup>196</sup> Memorandum from the Comm. on Energy & Com. Staff, to Members & Staff of the Subcomm. on Oversight & Investigations 7 (June 16, 2009), *available at* [http://democrats.energycommerce.house.gov/Press\\_111/20090616/rescission\\_supplemental.pdf](http://democrats.energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf); see also “Terminations of Individual Health Policies by Insurance Companies:” *Hearing Before the Subcomm. On Oversight and Investigations*, 111th Cong. 2 (2009) (statement of Bart Stupak, Chairman).

<sup>197</sup> Allison Bell, *NAIC Releases Health Policy Rescission Data Draft*, LIFEHEALTHPRO (Dec. 7, 2009), <http://www.lifehealthpro.com/2009/12/07/naic-releases-health-policy-rescission-data-draft>.

<sup>198</sup> *Id.*

certificates written.<sup>199</sup> In some instances, insurers, after rescinding a policy, would require rescinded insureds to pay back money already spent for medical care.<sup>200</sup>

Anecdotally, in 2007, many California doctors objected when Blue Cross California sent doctors letters asking if patients had failed to disclose a preexisting condition in their insurance application.<sup>201</sup>

If the ACA was repealed, many Americans would feel the loss of the rescission protections. Even policyholders who never have their policies rescinded would lose the peace of mind of knowing that their policy cannot be revoked due to an honest mistake in their application. Moreover, without this provision, an insurance company that chooses not to rescind policies for mistakes may be at a competitive disadvantage.

Certainly, insurers need the ability to protect themselves from individuals attempting to obtain coverage by fraud. And the ACA empowers insurers to rescind coverage in such instances. But the ability to rescind coverage based on an honest mistake in a policy application is too disruptive a power. It is also too tempting a tool to remove expensive policyholders. The loss of this protection would be particularly disruptive.

### *B. Changes to the Private Health Care Market*

#### *1. State-Based Exchanges*

The ACA requires that state-based exchanges be operational by January 1, 2014. Although a 2013 repeal would occur before that date, significant efforts and expenses will be incurred prior to a 2013 repeal. Thus, we consider state-based exchanges in evaluating the effects of a 2013 repeal.

The concept of an Exchange comes from the concept of “managed competition” credited to Alain Enthoven’s work in the late 1970s.<sup>202</sup> In the 1990s, a number of states implemented health insurance purchasing cooperatives.<sup>203</sup> Most have since failed,<sup>204</sup> although the Federal Employees Health Benefits Program and the California Public Employees’ Retirement System (CALPERS) are generally considered successful examples of insurance exchanges.<sup>205</sup> Medicare Advantage and Medicare Part D (discussed below) contain some elements of a health care

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<sup>199</sup> *Id.*

<sup>200</sup> *Curbing Insurance Cancellations*, HEALTHCARE.GOV (Sept. 23, 2010), <http://www.healthcare.gov/law/features/rights/cancellations/index.html>.

<sup>201</sup> See Lisa Girion, *Doctors Balk at Request for Data*, L.A. TIMES, Feb. 12 2008, available at <http://www.latimes.com/business/la-fi-bluecross12feb12,0,4319662.story>.

<sup>202</sup> Timothy S. Jost, *Health Insurance Exchanges in Health Care Reform Legal and Policy Issues 1* (Wash. & Lee Pub. Legal Stud. Res. Paper Series, Working Paper No. 2009-11), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1493369](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1493369).

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

exchange.<sup>206</sup> “The Massachusetts Connector is the most recent, and to date most successful, attempt to establish an exchange at the state level.”<sup>207</sup>

An exchange is a purely market-based approach, although in the context of the ACA, there is a strong government role in making the system work. Notably, the federal government will provide subsidies to individuals with household incomes up to 400% of the federal poverty level who purchase their insurance through Exchanges.<sup>208</sup> Under the ACA, each state must operate its own Exchange.<sup>209</sup> Some states, notably Massachusetts, established exchanges before the ACA was passed. Additionally, many private entities, including trade associations, have established exchanges to facilitate health insurance purchasing. Exchanges are designed to give the individual and small group markets the same purchasing power as the large group market.

Generally speaking, the large group health insurance market functions well in keeping premiums affordable and providing adequate benefits to enrollees, at least compared to the individual and small group markets.<sup>210</sup> Although premiums continue to rise in all three markets because of the ever-increasing cost of care, employers purchasing insurance in the large group market generally are able to negotiate lower premiums and more comprehensive benefits packages than the individual and small group markets. The reason for this is purchasing power: a larger group has more lives to offer, and therefore a broader risk pool, than an individual or an employer with fifty or fewer employees.<sup>211</sup>

Exchanges must be operational by January 1, 2014, and, because they are federally funded, must demonstrate operational readiness for federal approval by January 1, 2013,<sup>212</sup> just before the beginning of the next presidential term. In states that do not operate their own Exchange, the federal government will create and operate a federal fall-back that complies with federal specifications.<sup>213</sup>

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<sup>206</sup> *Id.*

<sup>207</sup> *Id.* at 1-2.

<sup>208</sup> 26 U.S.C. § 36B (Supp. 2010).

<sup>209</sup> The ACA leaves open the possibility for states to create regional Exchanges that operate across state lines. 42 U.S.C. § 18031(f) (Supp. 2010). These would be especially useful in states with smaller markets that require merging the markets in order to support a viable Exchange. Numbers are important in order to maximize purchasing power and broaden the risk pool. The ACA also permits states to create subsidiary Exchanges, or several Exchanges within a single state.

<sup>210</sup> See Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1580 (2011).

<sup>211</sup> *Id.*; see also Lawrence O. Gostin, *Socioeconomic Disparities in Health: A Symposium on the Relationships Between Poverty and Health*, 15 GEO J. ON POVERTY L. & POL'Y 571, 579 (2009).

<sup>212</sup> Exchanges can get conditional approval or begin operating after 2014. Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,913 (July 15, 2011). However, the federal government appears to want Exchanges to be operational by the beginning of 2014.

<sup>213</sup> Approval of a State Exchange, 76 Fed. Reg. 41,866, 41,913 (July 15, 2011).

To give an idea of the work that must go into creating Exchanges before they are operational and the benefits that they are expected to provide, we describe below the functions Exchanges are required to serve before evaluating the consequences to Exchanges of repealing the ACA.

*a. Functions*

Exchanges are envisioned to function as marketplaces for individuals and small businesses to purchase health insurance. As envisioned, they will provide a consumer-friendly experience. As it stands, health care, generally, is not automated. This includes purchasing health insurance in addition to health records and delivery. Consumers must go through long and complicated disclosures to have any idea what their plan covers, and few people take the trouble to do this unless they have a specific condition they know they need to have covered. Exchanges will simplify the process of purchasing health insurance by providing side-by-side comparisons of premiums and covered benefits across plans. They also are designed to help keep down costs by performing many of the administrative functions that issuers now pass on the cost of performing to individuals and small employers.<sup>214</sup>

The plans that are permitted to participate in Exchanges are called Qualified Health Plans (QHP).<sup>215</sup> Exchanges are charged with certifying qualified health plans to ensure that they comply with all federal and any state-specific standards. Many states that have created Exchanges since the ACA was enacted have decided on an open market model. That is, they have decided that any qualified health plan that meets the federal and state criteria will be able to participate in the Exchange.<sup>216</sup> In contrast, California has decided to give its Exchange the option of being a selective purchaser, meaning it would permit only a specified number of QHPs to offer their products in the Exchange and would select them through a competitive bidding process.<sup>217</sup>

To provide significant consumer assistance with benefits, each Exchange must operate a website through which individuals can compare and purchase plans.<sup>218</sup> The plans must be presented in a standardized manner so that consumers can make a meaningful comparison between them.<sup>219</sup> This approach has been likened to purchasing airline tickets: a person would be able to go to one website and compare premiums and benefits across plans, knowing that they have to cover minimum

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<sup>214</sup> Scott J. Macey & Kendra L. Roberson, *Employers and Health Insurance Exchanges have Shared Interests: Employers Should Care About Exchanges, States Should Care About Whether Employers Care*, 19 HEALTH CARE POL'Y REP. (BNA) 1716, 1721 (Nov. 7, 2011).

<sup>215</sup> 42 U.S.C. § 18021 (Supp. 2010).

<sup>216</sup> See, e.g., WASH. REV. CODE ANN. § 43.71.040(2)(e) (West 2012); OR. REV. STAT. ANN. §§ 11(3)-(4) (West 2012); COLO. REV. STAT. ANN. § 10-22-106 (West 2012); N.D. CENT. CODE ANN. § 26.1-54-01 (West 2012); IL. CENT. ST. 122/5-1-20; 2011 VA. ACTS 2011, c. 823 §§ 1-4; W. VA. CODE ANN. § 33-16G-4 (West 2012); MD. CODE ANN., INS. § 31-106 (West 2012); VT. STAT. ANN. tit. 33, § 1803 (West 2012).

<sup>217</sup> CAL. GOV'T CODE ANN. § 100503(c) (West 2012). The idea behind selective contracting is to enable Exchanges to negotiate better rates and benefits for enrollees, although it remains to be seen if it will be effective in doing so.

<sup>218</sup> 42 U.S.C. § 18031 (Supp. 2010).

<sup>219</sup> *Id.*

essential benefits and have several consumer protections built in. The website also is required to have an electronic calculator that an individual may use to determine precisely how much coverage will cost with the federal subsidies.<sup>220</sup>

Moreover, the Exchange must provide broad information to the public generally. It must operate a toll-free consumer hotline for enrollment, answering questions about coverage and addressing enrollee grievances.<sup>221</sup> In addition to performing its own outreach and public education,<sup>222</sup> it must create what is known as a Navigator program to go out into communities, especially hard-to-reach ones, and inform them about the opportunities for coverage in the Exchange and help enroll them in coverage.<sup>223</sup> Navigators must belong to one of several community-based groups, and must be trained in Exchange eligibility and enrollment to be able to assist members of the public through the application process.<sup>224</sup> Because Navigators will need time to build all of the community relationships necessary to perform effective outreach, they will need to be selected at least six months before the first Exchange open enrollment period, or March 2013 at the latest.

Part of the health care reform was to create what is known as a “no wrong door” policy in applying for government health insurance programs (or what are called “health insurance affordability programs” in proposed regulations<sup>225</sup>), including the Exchange. Under this arrangement, individuals who apply to the Exchange<sup>226</sup> are screened automatically<sup>227</sup> for other health insurance affordability programs that may require either no premium payment or a significantly lower premium, such as Medicaid, CHIP, and, in states that enact one, the Basic Health Program.<sup>228</sup> The idea is to encourage members of the public to apply for these programs and to facilitate them doing so by not requiring them to run from government office to government office to apply for different programs. This is a laudable development that will make the lives of people who depend on health insurance affordability programs much easier.

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<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> Required Consumer Assistance Tools and Programs of an Exchange, 76 Fed. Reg. 41,866, 41,915 (July 15, 2011).

<sup>223</sup> 42 U.S.C. § 18031(i) (Supp. 2010).

<sup>224</sup> *Id.*

<sup>225</sup> *See, e.g.*, Background, 76 Fed. Reg. 50,931, 50,932 (Aug. 17, 2011).

<sup>226</sup> If you apply to the Exchange and do not want federal subsidies of any sort then you may skip the eligibility determination for other programs. Exchange Functions in the Individual Market: Eligibility Determinations, 76 Fed. Reg. 51,202, 51,231 (Aug. 17, 2011).

<sup>227</sup> 42 U.S.C. §§ 18031, 18083 (Supp. 2010).

<sup>228</sup> The ACA permits states to enact what is known as a Basic Health Program. Enrollees in this program would receive health insurance without having to pay a premium. Individuals with household income between 133-200% of the federal poverty level—low-income individuals not eligible for Medicaid—would be eligible. 42 U.S.C. § 18051 (Supp. 2010). States would receive 95% of the premium tax credits and cost-sharing subsidies that the federal government otherwise would have spent on providing subsidies to those individuals. *Id.*



The no wrong door policy also presents a tremendous information technology challenge to Exchanges. Exchanges must determine eligibility for three or four different programs for each individual who walks through the physical or electronic door. This administrative complexity will require significant investment in information technology able to perform those determinations. These systems must be at an advanced stage of development well before 2013 to be operational by 2014, as expected.

Exchange operations are funded until 2015 with federal grants.<sup>229</sup> To date, forty-nine states have received \$511 million to get their systems up and running.<sup>230</sup> After 2015, Exchanges must be self-sufficient and are not permitted to receive federal funds for operations.<sup>231</sup> It is envisioned that most states will fund Exchange operations by levying a fee on plans that participate in the Exchange.<sup>232</sup> Issuers are expected to want to participate because they will have a large, subsidized, guaranteed market for their products, so they will be willing to pay a fee that assures the market keeps operating in order to participate in it. States are permitted to fund their Exchange operations through other means.<sup>233</sup> It is uncertain whether any states will commit significant state resources to funding because of state budget constraints.<sup>234</sup>

A major incentive for individuals to purchase their health insurance through Exchanges is the federal subsidies.

#### *b. Federal Subsidies*

To be eligible to purchase insurance through an Exchange, an individual need meet only three criteria where an individual must: (1) not be incarcerated; (2) be lawfully present; and (3) be a resident of the Exchange's service area.<sup>235</sup> However, many people purchasing their health insurance through Exchanges will do so because they are eligible for the federal subsidies, which take two forms: premium tax credits and cost-sharing subsidies.

Premium tax credits are refundable tax credits paid by the federal government to ensure that a qualifying individual does not have to pay more than a specified percentage of income on health insurance premiums. Generally, individuals whose household income is between 139 and 400% of the federal poverty level are eligible for the tax credits.<sup>236</sup> The credits are graduated: the higher income bracket an

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<sup>229</sup> 42 U.S.C. § 18031 (Supp. 2010).

<sup>230</sup> *Creating a New Competitive Marketplace: Health Insurance Exchange Establishment Grants Awards List*, HEALTHCARE.GOV, <http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html> (last visited Apr. 16, 2012).

<sup>231</sup> 42 U.S.C. § 18031 (Supp. 2010).

<sup>232</sup> *Id.*

<sup>233</sup> *Id.*

<sup>234</sup> See CAL. GOV'T CODE ANN. § 100521 (West Supp. 2010) (prohibiting the use of state General Fund money to operate the Exchange without a subsequent appropriation).

<sup>235</sup> 42 U.S.C. § 18032 (Supp. 2010). Additionally, members of Congress are required to purchase their insurance through Exchanges. *Id.*

<sup>236</sup> 26 U.S.C. § 36B (Supp. 2010). Certain groups, notably lawful permanent residents who are not yet eligible for Medicaid because they have not lived in the country long enough, are

individual is in, the higher the percentage of household income the individual must pay for health insurance premiums.<sup>237</sup> The tax credits are advanceable: If the individual's income is estimated at the beginning of the plan year, the federal government will pay the individual's health plan the difference between the individual's contribution to the premium and the full cost. In either case, the premium tax credit payments may be reconciled at the end of the year to ensure that the individual paid the correct amount based on the actual rather than estimated income.<sup>238</sup> The individual may owe extra taxes, or be owed additional refunds, if the amounts are calculated incorrectly during the year.

If an individual is eligible for employer-sponsored coverage, he or she may receive premium tax credits only if the employer-sponsored coverage is not affordable or does not provide minimum value. "Unaffordable" means the individual's contribution to the premium is greater than 9.5% of household income.<sup>239</sup> "Minimum value" means that the plan covers at least 60% of the cost of covered benefits.<sup>240</sup>

The second federal subsidy in the Exchange is known as the cost-sharing subsidy. Individuals with household incomes from 139-250% of the federal poverty level are eligible for the cost-sharing subsidy, which reduces the amounts that they must pay out of pocket for medical care. The cost-sharing subsidy is graduated as well: the higher a person's income bracket, the higher the individual's required out-of-pocket payment.<sup>241</sup> At the end of the tax year, the federal government pays the issuer the difference between the actual cost and the individual's contribution.

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eligible for premium tax credits no matter how low their income. 26 U.S.C. § 26 (Supp. 2010).

<sup>237</sup> The percentages are for up to 133% of federal poverty level, 2% of income; 133-150% of federal poverty level, 3-4% of income; 150-200% of federal poverty level, 4-6.3% of income; 200-250% of federal poverty level, 6.3-8.05% of income; 250-300% of federal poverty level, 8.05-9.5% of income; and 300-400% of federal poverty level, 9.5% of income. 26 U.S.C. § 36B (Supp. 2010).

<sup>238</sup> *Id.*

<sup>239</sup> *Id.* Significantly, affordability is measured with respect to household income but self-only coverage for the employee. *Id.*; see also 26 U.S.C. § 5000A (Supp. 2010). This means that an employee with dependents has the entire household's income but only the self-only contribution considered when determining whether the contribution is above 9.5% of income. This is the worst possible combination for the employee, and is likely to leave many working individuals with dependents both unable to afford dependent coverage through their employers and ineligible to receive tax credits through the Exchange. It is one of the most significant inequities in the Affordable Care Act, although it is sure to bring down the cost of the subsidies to the federal government.

<sup>240</sup> 26 U.S.C. § 36B (Supp. 2010). In addition to the inequity mentioned above, dependents are ineligible for premium tax credits through the Exchange if their parent enrolls in employer-based coverage and they are eligible for coverage under that coverage as well, even if the employer does not contribute a penny to that coverage.

<sup>241</sup> 42 U.S.C. § 18071 (Supp. 2010). However, the Department of Health and Human Services has noted that because of the mathematical calculations, the cost-sharing subsidies actually run out for individuals at 250% of federal poverty level. Exchange Functions in the Individual Market: Eligibility Determinations, 76 Fed. Reg. 51,202, 51,209 (Aug. 17, 2011). Whether this was deliberate or simply an oversight when creating the statute is unclear.

*c. Consequences of Repeal*

One may be tempted to take comfort in the fact that many states have established Exchanges after the ACA was passed. Under this view, repeal is not a cause for concern because the states may carry on the work the federal government would abandon if it repealed the ACA. Although many states are committed to making health care reform work, for political and fiscal reasons, the states will have a hard time doing so without national collective action and federal support.

Repeal would impose a significant barrier to Exchange success. There are many political and practical challenges to creating and operating Exchanges, even with federal support. Even those states that have enough political support to have created Exchanges will have difficulties if the enrollees do not receive premium assistance and are not required to buy insurance. Without premium assistance and a requirement to obtain health insurance, the incentives to sign up will be far less and adverse selection is a much greater possibility. Additionally, there would be no federal fall-back in states that have not enacted enabling legislation for Exchanges. Facing those challenges without federal support would be difficult.

Funding Exchange startup and operations would be very difficult for cash-strapped states without federal assistance. Until 2015, Exchange operations are supposed to be funded with federal grants. Without those grants, state Exchanges would have difficulty funding their own operations. Many states lack the political will or the funds to fund this area of massive expansion with state money at the same time the states are cutting back nearly all other public assistance programs.<sup>242</sup> And although states can support their Exchanges with fees on participating plans, this does them little good in 2013, a year before there are any participating plans.

Significantly, there will be no federal subsidies for Exchange enrollees. Without subsidies, and without an individual mandate that penalizes individuals who do not purchase insurance, many uninsured will not be sufficiently motivated to buy insurance because of the mere existence of Exchanges and the benefits that collective purchasing may bring. To be sure, health insurance that is purchased through an Exchange is likely to be more affordable and have better coverage than insurance currently offered on the individual and small group markets because of the heightened purchasing power available to larger groups. However, without the substantial subsidies envisioned in the ACA, insurance coverage likely will remain unaffordable for many who now lack it. Generally, the most likely groups who will be willing to buy insurance through an Exchange in those circumstances, assuming they would be able to without guaranteed issue, would be the high-risk individuals for whom purchasing insurance is less expensive than self-insuring and paying out of pocket. This possible adverse risk selection would increase the difficulty of operating an Exchange.

True, there have been and continue to be Exchanges that are successful on their own and without government support. However, these tend to be organized by trade associations whose members support the idea of an Exchange as a means of increasing their purchasing clout. Many earlier versions of unsubsidized Exchanges for individuals or small businesses ultimately failed because of adverse risk selection. State-based Exchanges would risk suffering the same fate.

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<sup>242</sup> See, e.g., CAL. GOV'T CODE ANN. § 100521 (West 2012) (stipulating that state General Fund moneys are not to be spent on Exchange activities without subsequent appropriation).

If that happens, all of the effort and expense involved in creating state-based Exchanges and the federal fall-back will have been for nothing. More importantly, the individual and small group markets will continue to be dysfunctional, and health insurance will be too expensive for upwards of a fifth of the country.

## 2. Medical Loss Ratios

Beginning in plan years following January 1, 2011, the ACA imposes medical loss ratio requirements on health insurance issuers.<sup>243</sup> Issuers are required to spend a specified percentage of the enrollee premiums on patient care for covered benefits. Patient care includes “reimbursement for clinical services provided to enrollees;” and “activities that improve health care quality.”<sup>244</sup> Patient care excludes “all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.”<sup>245</sup> For individual and small group issuers, patient care must equal at least 80% of premiums; for large group issuers, 85%.<sup>246</sup> Thus, issuers cannot have administrative expenses and profits (and any other expenses besides enrollee claims) that are larger than either 20% or 15%. At the end of the year, if an issuer pays less than those percentages of premiums in its enrollees’ claims, it must issue rebates to the enrollees until it meets the applicable percentage.<sup>247</sup>

These requirements are expected to be manageable. Indeed, on October 31, 2011, the Government Accountability Office (GAO) issued a report concluding that 2010 medical loss ratio data demonstrated that most insurers would have met or exceed medical loss ratio requirements.<sup>248</sup>

Prior to the ACA, the absence of a medical loss ratio requirement had two significant consequences for the market. First, without a medical loss ratio, issuers had much more freedom to raise premiums to accommodate increased administrative expenses or to attempt to increase profits. This placed ever-upward pressure on premiums and made it harder for consumers to get good value for their premium dollars.

Second, absent medical loss ratio requirements, issuers were freer to engage in “risk classification by design.”<sup>249</sup> Risk classification by design occurs when an insurer designs its plans so that certain plans will attract healthier enrollees and other plans will attract sicker enrollees.<sup>250</sup> This method takes advantage of adverse selection. Generally, issuers achieve this by sculpting covered benefits and premiums to attract only healthier individuals to certain plans. Risk classification by

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<sup>243</sup> 42 U.S.C. § 300gg-18 (Supp. 2010).

<sup>244</sup> *Id.*

<sup>245</sup> *Id.*

<sup>246</sup> *Id.*; see also 45 C.F.R. §§ 158.210, 158.211 (2011).

<sup>247</sup> 42 U.S.C. § 300gg-18 (Supp. 2010).

<sup>248</sup> U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-12-90R, PRIVATE HEALTH INSURANCE: EARLY INDICATORS SHOW THAT MOST INSURERS WOULD HAVE MET OR EXCEEDED NEW MEDICAL LOSS RATIO STANDARDS (2011).

<sup>249</sup> Baker, *supra* note 210, at 1612–14.

<sup>250</sup> *Id.* at 1588.

design becomes a problem when issuers place restrictions on the plans that are designed for high-risk individuals and give them inferior coverage where possible, or when an issuer simply does not offer any plans that would appeal to a high-risk individual.

Risk classification by design could become a significant problem, even in a post-2014 world providing guaranteed issue, if left unchecked by medical loss ratio requirements. Even if everyone is eligible (under ACA provisions taking effect in 2014) to purchase any plan without a higher premium based on a preexisting condition, issuers could design their products to subvert the guaranteed issue requirements. If an issuer designs its plans to be unattractive to high-risk individuals, guaranteed issue and community rating could be thwarted. For a sick individual needing coverage, the theoretical ability to purchase any plan is of limited value if no plan that would meet that individual's needs exists.

The medical loss ratio is one tool to minimize the incentive to engage in risk classification by design. If issuers must pay a certain percentage of premium dollars on claims, no matter what the claims and the premiums are, insurers will be less likely to seek to turn away higher-risk individuals. No matter what, the issuer must spend at least the specified percentage of premiums on claims or issue a refund. If an issuer designs its plans to ensure that only very healthy individuals, who rarely use medical services, enroll, the insurer could not increase its profit from this strategy. It would have to pay back the excess premiums to the enrollees. Theoretically, at least, the issuers would welcome higher-risk individuals as long as it can calibrate premiums to be around the percentage it expects to have to pay.<sup>251</sup>

A repeal of the medical loss ratio requirement would leave it to the market to calibrate risk across issuers. Experience has shown the market does a poor job at this. Repeal would mean not only that premiums could keep increasing even faster than the cost of care, but that issuers would have one less restriction on their ability to discriminate against people with significant medical needs.

### 3. Expansion of Preventive Services

A common criticism of United States health care is that it spends significant amounts on expensive end-of-life and emergency care, while spending comparatively little on cost-effective preventive and primary care.<sup>252</sup> ACA seeks to reverse that trend by requiring preventive care to be covered free from co-pay or cost sharing.

All insurance plans offering group or individual coverage with a plan or policy year starting after September 23, 2010 must provide preventive care to enrollees free from co-pay, deductible, or coinsurance.<sup>253</sup> The preventive coverage must include

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<sup>251</sup> Issuers still would want to have enough of a risk balance so that premiums are not so high that they discourage lower-risk individuals from signing up for their plans. The Affordable Care Act also provides for an elaborate, permanent risk adjustment system for plans with lower-risk enrollees to compensate plans with higher-risk enrollees. 42 U.S.C. § 18063 (Supp. 2010). With all of these arrows in the quiver, risk is more likely to be spread evenly across the market.

<sup>252</sup> See, e.g., KAISER, UNINSURED, *supra* note 36, at 11 (The uninsured, who are less likely to receive timely preventive care, are often diagnosed in later stages of diseases, including cancer, and die earlier than those with insurance.)

<sup>253</sup> 42 U.S.C. 300gg-13 (Supp. 2010); 45 C.F.R. § 147.130 (2011).

evidence-based items or services, rated “A” or “B” by the United States Preventive Services Task Force.<sup>254</sup> These services include: breast cancer screening; breastfeeding counseling; colorectal cancer screening; healthy diet counseling; hearing loss screening for newborns; osteoporosis screening for women; tobacco use and cessation counseling; and sexually transmitted infections counseling.<sup>255</sup>

Also included are immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.<sup>256</sup> These include Hepatitis, Influenza, Polio, and Rabies.<sup>257</sup>

For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration are also included.<sup>258</sup> For women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration are also included.<sup>259</sup>

Insurers, however, have no obligation to provide preventive coverage not expressly required by ACA.<sup>260</sup> Similarly, plans may cover preventive services that have not been recommended.<sup>261</sup>

Starting January 1, 2011 the preventive services without cost shifting applied to Medicare enrollees.<sup>262</sup> These include a yearly wellness exam, tobacco use counseling, and screenings.<sup>263</sup> These changes have had a significant effect. In the first seven months of 2011, 17,336,421 people, (51.5% of Medicare enrollees) received one or more free preventive services.<sup>264</sup> 1,061,780 took advantage of the new Annual Wellness Visit.<sup>265</sup>

Still, it is not fair to say that preventive care will always reduce costs. Screenings for diseases only incurred by a very small fraction of the population are not likely to

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<sup>254</sup> 42 U.S.C. 300gg–13 (Supp. 2010).

<sup>255</sup> A full list of “A” or “B” recommended services may be found at: *USPSTF A and B Recommendations*, U.S. PREVENTATIVE SERV. TASK FORCE (Aug. 2010), <http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm>.

<sup>256</sup> 42 U.S.C. 300gg–13 (Supp. 2010).

<sup>257</sup> A full list of recommended vaccines may be found at: *Advisory Committee for Immunization Practices (ACIP) Recommendations*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 30, 2012), <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>.

<sup>258</sup> 42 U.S.C. § 300gg–13 (Supp. 2010).

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> *Medicare Preventive Services*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/features/65-older/medicare-preventive-services/index.html> (last updated Feb. 6, 2012).

<sup>263</sup> *Id.*

<sup>264</sup> U.S. Dep’t Health & Human Services, *Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole*, HHS.GOV (Aug. 4, 2011), <http://www.hhs.gov/news/press/2011pres/08/20110804a.html>.

<sup>265</sup> *Id.*

be cost effective.<sup>266</sup> One review cautioned that “[c]areful analysis of the costs and benefits of specific interventions, rather than broad generalizations, is critical.”<sup>267</sup> However, by tying required preventive care to those recommended by sources such as the United States Preventive Services Task Force, the ACA avoids the risk of painting with too broad a brush.

Thus, the loss of this provision, through a 2013 repeal, would likely increase costs and worsen health outcomes. Moreover, the popularity of this provision, as demonstrated by over one million Medicare recipients who took advantage of the new Annual Wellness Visit, suggests that the loss of this provision would be particularly acute for many Americans, chiefly those who would see a co-pay or cost share reappear on their bill.

#### 4. Small Business Tax Credit

Since 2010, the ACA has provided tax credits for small employers with up to twenty-five employees.<sup>268</sup> Those employers can receive up to 50% of their required contributions to employee health benefits from the government in the form of tax credits.<sup>269</sup> To be eligible for the credit, an employer must contribute at least half of the premium cost for coverage.<sup>270</sup> After 2014, small employers can receive the tax credit for only two consecutive years.<sup>271</sup>

Under this provision, small businesses now have access to the same premium support that low-income individuals will have in 2014 when they purchase through Exchanges. Like individuals, many small businesses are priced out of the health insurance market. Even though many small business owners would like to provide their employees with health insurance—because it is good business and because they believe it is the right thing to do for their employees—it remains unaffordable. Issuers often pass on higher administrative costs to small businesses. Employer contributions to health insurance premiums tend to be much higher for small businesses than for large businesses. This leaves small business owners unable to purchase health benefits even when they wish to do so. The small business tax credit is one means of encouraging small employers to provide those benefits.

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<sup>266</sup> See Joshua Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates* 358 *NEW ENG. J. MED.* 661, 662-63 (2008).

<sup>267</sup> *Id.*

<sup>268</sup> 26 U.S.C. § 45R (Supp. 2010).

<sup>269</sup> *Id.*

<sup>270</sup> William Pitsenberger, *What Health Care Reform Means to Your Clients (and You)*, *J. KAN. B. ASS'N* 28, 29 (Nov./Dec. 2010).

<sup>271</sup> 26 U.S.C. § 45R (Supp. 2010). It appears that Congress initially provided for only two years post-2014 with the intention to make the small business tax credit permanent after initial passage. However, given the fiscal climate in the federal government and the attitude towards entitlement programs, it is very unlikely that it will be made permanent any time soon. The time limit on small business tax credits is yet another area in which Congress appears to have sacrificed more expansive coverage in favor of a cleaner balance sheet when the bill was scored.

However, the takeup of the tax credit has been much less than expected. By one estimate, only 14% of eligible businesses have taken advantage of the credit.<sup>272</sup> According to another report, only 10% of California small business owners say they are aware of the tax credits currently in effect.<sup>273</sup> There are several possible explanations for this, including the doubts about the future of the credit and the disruption that would be caused if small employers' employees lose their coverage once it becomes unaffordable to the employer, as well as lack of information and misinformation.

Because fewer small businesses have taken advantage of this provision, the loss of it, due to repeal would be less dramatic than if the provision had seen a larger takeup. Still, many individuals have acquired employer-sponsored coverage because their small employers have the tax credit. If insurance becomes unaffordable once again for those small employers, they are likely to drop coverage. Employees losing coverage would be forced to fend for themselves on the individual market—unless they qualify for public assistance. And if this were combined with the loss of the Exchanges and expansions of insurance affordability programs, those newly uninsured individuals would be much more likely to remain uninsured.

### C. Changes to Medicare

#### 1. The Medicare Advantage Savings

Starting in 2011, the ACA addresses overpayments to Medicare Part C, “Medicare Advantage” programs. Medicare Advantage allows Medicare eligible Americans to enroll in a government subsidized, privately run, Medicare alternative insurance, in lieu of traditional government run Medicare.<sup>274</sup> Medicare Advantage plans are required to cover Medicare’s basic benefits.<sup>275</sup> Plans that receive rebates (a subsidy that plans receive to provide extra benefits) must provide additional benefits, such as vision care or dental care, or subsidies of beneficiaries’ out-of-pocket costs.<sup>276</sup> The most common added benefit is cost-share reduction for Part A and B services; 54% of rebate dollars went towards this use.<sup>277</sup> In 2010, Medicare

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<sup>272</sup> Karen E. Klein, *Why Few Employers Use Health-Care Tax Credits*, BLOOMBERG BUSINESSWEEK (Nov. 15, 2011), <http://www.businessweek.com/small-business/why-few-employers-use-healthcare-tax-credits-11152011.html>.

<sup>273</sup> INSIGHT AT PAC. CMY. VENTURES, HEALTH CARE SMALL BUSINESS: UNDERSTANDING HEALTH CARE DECISION MAKING IN CALIFORNIA (Oct. 2011) *available at* [http://www.pacificcommunityventures.org/insight/reports/Health\\_Care\\_and\\_Small\\_Business\\_2011.pdf](http://www.pacificcommunityventures.org/insight/reports/Health_Care_and_Small_Business_2011.pdf).

<sup>274</sup> KAISER FAM. FOUND., MEDICARE AT A GLANCE (Nov. 2011), *available at* [http://www.kff.org/medicare/upload/1066\\_11.pdf](http://www.kff.org/medicare/upload/1066_11.pdf).

<sup>275</sup> *Id.*

<sup>276</sup> *Id.*

<sup>277</sup> MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 268 (2010), *available at* [http://medpac.gov/documents/Mar10\\_EntireReport.pdf](http://medpac.gov/documents/Mar10_EntireReport.pdf) [hereinafter MEDPAC 2010 REPORT].



Advantage enrollment increased to 11.4 million beneficiaries, 24% percent of all Medicare beneficiaries.<sup>278</sup>

Medicare Advantage plans are reimbursed based on the plan's "'bid' (the dollar amount the plan estimates will cover the Part A and Part B benefit for a beneficiary of average health status) and the 'benchmark' in that payment area (the maximum amount of Medicare payment set by law for a [Medicare Advantage] plan to provide Part A and Part B benefits)."<sup>279</sup> If a plan's bid exceeds the benchmark, the plan is reimbursed at the benchmark level and enrollees must pay the difference through additional premiums.<sup>280</sup> If a plan's bid is less than the benchmark, the plan receives its bid, plus a bonus "rebate" of 75% of the difference.<sup>281</sup> Benchmarks are often set well above what Medicare's cost of providing similar benefits.<sup>282</sup>

In 2009 the average benchmark for Medicare Advantage plans was estimated at 118% of traditional Medicare costs.<sup>283</sup> The average bid was 102% and the average payment was 114%.<sup>284</sup> Thus, Medicare Advantage enrollees cost, on average, 14% more than comparable Medicare Parts A and B enrollees.<sup>285</sup> Put differently, the government spends, on average, over \$1,000 more per Medicare Advantage enrollee than a traditional Medicare enrollee.<sup>286</sup> In 2009, these overpayments cost Medicare \$14 billion.<sup>287</sup> In 2011, the same figures are estimated to be: benchmarks, 113%; bids, 100%; and payments, 110%.<sup>288</sup>

Reform rolls back Part C expenditures. In 2011, it freezes Medicare Advantage benchmarks at 2010 levels for each county.<sup>289</sup> In 2012, it sets local benchmarks equal to local average Medicare spending, multiplied by a figure ranging from 95% to 115% based on the local spending levels.<sup>290</sup> Changes are phased in over three, five, or seven years depending on the level of payment reduction.<sup>291</sup>

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<sup>278</sup> MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 285 (2011), available at [http://www.medpac.gov/chapters/Mar11\\_Ch12.pdf](http://www.medpac.gov/chapters/Mar11_Ch12.pdf) [hereinafter MEDPAC 2011 REPORT].

<sup>279</sup> MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 257 (2009), available at [http://www.medpac.gov/chapters/Mar09\\_Ch03.pdf](http://www.medpac.gov/chapters/Mar09_Ch03.pdf) [hereinafter MEDPAC 2009 REPORT]; see also CBO PUBLICATIONS, *supra* note 39 at 66 ("The benchmarks currently range from about 100 percent to over 150.").

<sup>280</sup> *Id.* at 257.

<sup>281</sup> *Id.*

<sup>282</sup> *Id.*

<sup>283</sup> *Id.* at 258.

<sup>284</sup> *Id.*

<sup>285</sup> *See id.*

<sup>286</sup> *The Affordable Care Act—Implementation Timeline*, WHITEHOUSE.GOV <http://www.whitehouse.gov/healthreform/timeline> (last visited Apr. 16, 2012).

<sup>287</sup> MEDPAC 2010 REPORT, *supra* note 277, at 260.

<sup>288</sup> MEDPAC 2011 REPORT, *supra* note 278, at 293.

<sup>289</sup> *Id.*

<sup>290</sup> *Id.*; see also 42 U.S.C. § 1395w-23 (Supp. 2010).

<sup>291</sup> *See* 42 U.S.C. § 1395w-23 (Supp. 2010).

The ACA also applies, beginning in 2014, a Medical Loss Ratio of 85% to Medicare Advantage plans.<sup>292</sup> Plans with administrative expenses exceeding 15% must return the difference to Medicare.<sup>293</sup> And if a plan fails to satisfy the loss ratio for three consecutive years, the Secretary must bar the plan from admitting new enrollees for the second succeeding contract year.<sup>294</sup> If a plan fails to satisfy the loss ratio for five consecutive contract years, the Secretary must terminate the plan's contract.<sup>295</sup> However, for purposes of this analysis, we note that the loss ratio requirements will not take effect before January 2013.

The Congressional Budget Office projects that, from 2010 to 2019, these reductions will save \$117 billion.<sup>296</sup> These savings will help fund the Medicaid expansion.

The ACA and accompanying regulations also limit a Medicare Advantage plan's ability to encourage unhealthy enrollees to drop the plan in favor of traditional Medicare. Prior to the ACA, Medicare Advantage plans would impose larger cost sharing amounts on procedures associated with less healthy enrollees, to encourage such enrollees to enroll in basic Medicare. The ACA limits such cost sharing under Medicare Advantage plans.<sup>297</sup> Plans cannot exceed the cost sharing imposed under basic Medicare for specific services including: chemotherapy and renal dialysis.<sup>298</sup> The ACA empowers the Secretary to add services that require "a high level of predictability and transparency for beneficiaries."<sup>299</sup>

Additionally, to encourage high quality care, Medicare Advantage plans that receive high rankings from enrollees will receive bonus payments.<sup>300</sup>

Without the Medicare Advantage cost reduction measures, the CBO projects that the number of Medicare beneficiaries enrolled in Medicare Advantage plans will grow from 10.6 million in 2009 to 13.9 million in 2019.<sup>301</sup> The amount by which payments to those plans will exceed their bids will grow from an average of \$87 per member per month in 2009 to \$135 per member per month in 2019.<sup>302</sup> These additional expenses, absent the ACA, would further threaten Medicare's long-term fiscal stability.

Moreover, Medicare Advantage plans would lose the incentive to provide high-quality care in order to receive bonus payments. And conversely, such plans would

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<sup>292</sup> 42 U.S.C. § 1395w-27(e) (Supp. 2010).

<sup>293</sup> *Id.*

<sup>294</sup> *Id.*

<sup>295</sup> *Id.*

<sup>296</sup> CBO PUBLICATIONS, *supra* note 39 at 67.

<sup>297</sup> 42 U.S.C. § 1395w-22 (Supp. 2010).

<sup>298</sup> *Id.*

<sup>299</sup> Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes, 76 Fed. Reg. 21,432-01 (Apr. 15, 2011).

<sup>300</sup> 42 U.S.C. § 1395w-23 (Supp. 2010).

<sup>301</sup> CBO PUBLICATIONS, *supra* note 39 at 66.

<sup>302</sup> *Id.*

again have an incentive to “lemon-drop” expensive enrollees through cost-sharing measures.

Put simply, a loss of this provision would put additional cost strain on an already high-cost system. That said, because Medicare Advantage cost reductions are phased-in and because the medical loss ratio requirements do not take effect until 2014, by the time of an early 2013 repeal, the full effect of these costs savings will not yet be felt.

## 2. Closing the “Donut Hole”

By January 20, 2013, the ACA will have made important steps towards closing the Medicare Part D “Donut Hole.” The donut hole is the gap in prescription drug coverage under Medicare Part D. Part D provides prescription drug benefits to enrollees. It covers roughly 74% of the drug’s cost (enrollees pay a deductible and a 25% coinsurance), but only until expenditures reach specified amount (\$2,510 in 2008; \$2,840 in 2011).<sup>303</sup> Part D enrollees must then pay out-of-pocket for prescriptions until the combined payments of the enrollee and Medicare have reached a specified out of pocket threshold (\$5,726.25 in 2008; \$6,447.50 in 2011).<sup>304</sup> Then the enrollee need only cover 5% of the cost of drugs and Part D picks up the remaining 95%.

The donut hole is a byproduct of the peculiar creation of Medicare Part D. The original Medicare was created in 1965, before insurance policies typically covered outpatient prescription drugs.<sup>305</sup> Thus drugs were not included in Medicare.<sup>306</sup> In 1988, Medicare was briefly expanded to include prescription drugs through the Medicare Catastrophic Coverage Act.<sup>307</sup> It was repealed in 1989, before it went into effect, largely due to protests over the act shifting more costs to higher income Medicare recipients.<sup>308</sup> Prescription drugs were finally added in 2003 and the benefit became effective in 2006.

From the start, Part D was designed to promote industry interests and serve conservative ideals.<sup>309</sup> Costs could not exceed \$400 billion over ten years.<sup>310</sup> Part D had to include partial means testing.<sup>311</sup> The program had to be voluntary and administered by private prescription drug plans or “PDPs.”<sup>312</sup> The donut hole is a cost savings mechanism to serve as a stop-loss. However, Medicare was not

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<sup>303</sup> 2012 Medicare Part D Outlook, Q1MEDICARE.COM, <http://www.q1medicare.com/PartD-The-2012-Medicare-Part-D-Outlook.php> (last visited Apr. 16, 2012).

<sup>304</sup> *Id.*

<sup>305</sup> FURROW ET AL., *supra* note 74, at 781.

<sup>306</sup> *Id.*

<sup>307</sup> DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES 41-42 (2006).

<sup>308</sup> *See id.* at 42.

<sup>309</sup> *See* FURROW ET AL., *supra* note 74, at 781.

<sup>310</sup> *Id.* at 782.

<sup>311</sup> *See id.*

<sup>312</sup> *Id.* at 781.

permitted to negotiate lower drug prices.<sup>313</sup> Instead, PDPs would individually negotiate drug prices.<sup>314</sup> Medicare administered prices for prescription drugs could not be used.<sup>315</sup>

The ACA is designed to close the donut hole by 2020. In 2010, it gave \$250 to enrollees who had reached the donut hole, as a means to partially address the cost of reaching the hole.<sup>316</sup> In 2011, the ACA gives enrollees a 50% discount on brand name drugs and 7% for generics.<sup>317</sup> The discounts increase every year as follows:

	Brand Name Discount	Generic Drugs Discount
2011	50%	7%
2012	50%	14%
2013	52.5%	21%
2014	52.5%	28%
2015	55%	35%
2016	55%	42%
2017	60%	49%
2018	65%	56%
2019	70%	63%
2020	75%	75%

By 2020, both generics and brand name drugs receive a 75% discount—the same discount that a Part D enrollee receives—effectively closing the donut hole.

Notably though, the ACA does not allow the Secretary to use her bargaining power to negotiate lower drug prices or to require comparative effectiveness studies in connection with purchasing.<sup>318</sup> Although, as discussed below, the Independent Payment Advisory Board may mitigate Medicare's lack of negotiation power.

The effect of this provision is accelerating both in the number of recipients benefiting and in the amount of the benefits. In the first half of 2011, 899,000 Medicare recipients received the 50% discount on brand name drugs in the donut

<sup>313</sup> 42 U.S.C. § 1395w-111(i) (Supp. 2010)

Noninterference: In order to promote competition under this part and in carrying out this part, the Secretary—(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

*Id.*

<sup>314</sup> See Susan Adler Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will it be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 253-54 (2006).

<sup>315</sup> FURROW ET AL., *supra* note 74, at 781.

<sup>316</sup> 42 U.S.C. § 1395w-152(c)(1) (Supp. 2010).

<sup>317</sup> See 42 U.S.C. § 1395w-102 (Supp. 2010).

<sup>318</sup> See Brian Wingfield et al., *Health Reform's Winners and Losers*, FORBES.COM (Mar. 21, 2010, 10:50 PM), <http://www.forbes.com/2010/03/21/health-care-vote-business-beltway-congress.html>.

hole.<sup>319</sup> The out-of-pocket savings in that period equaled \$461 million.<sup>320</sup> And \$200 million was saved in June alone.<sup>321</sup> In all of 2011, nearly 4 million seniors and people with disabilities received \$2.1 billion in discounts when they hit the donut hole.<sup>322</sup> And the average benefit grew to \$604 per person.<sup>323</sup>

If the ACA is repealed, millions of Part D enrollees will lose their discount. Or, if pharmaceutical companies choose to continue the discount, it is unlikely that the additional discounts will be phased in, and almost certainly discounts for generic drugs will not be phased in. Moreover, the gap will remain open, and continue to threaten the savings of elderly Americans. Indeed, in 2007, 26% of Part D enrollees who received prescriptions, and did not receive low-income subsidies, reached the gap.<sup>324</sup> 15% of such enrollees incurred expenses high enough to reach the other side of the gap and had to absorb the roughly \$3,000 cost.<sup>325</sup> More than a quarter of those hitting the donut hole stop taking their prescriptions.<sup>326</sup>

### 3. The Independent Payment Advisory Board (IPAB)

The Independent Payment Advisory Board (IPAB) is one of the more controversial elements in the ACA. However, it stands to achieve significant cost-savings for Medicare.

The President will appoint, “with the advice and consent of the Senate,” fifteen full time members to the Independent Payment Advisory Board.<sup>327</sup> Each board member serves for a six-year term, and may not serve more than two consecutive terms.<sup>328</sup> Administrative funding becomes available October 1, 2011.<sup>329</sup> Starting in 2012 the IPAB is funded \$15,000,000 a year, adjusted for inflation.<sup>330</sup>

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<sup>319</sup> *Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole*, HHS.GOV (Aug. 4, 2011), <http://www.hhs.gov/news/press/2011pres/08/20110804a.html>.

<sup>320</sup> *Id.*

<sup>321</sup> *Id.*

<sup>322</sup> *ASPE Issue Brief: Medicare Beneficiary Savings and the Affordable Care Act*, ASPE.HHS.GOV (Feb. 2, 2012), <http://aspe.hhs.gov/health/reports/2012/MedicareBeneficiarySavings/ib.shtml>.

<sup>323</sup> *Id.*

<sup>324</sup> JACK HOADLEY ET AL., *THE MEDICARE PART D COVERAGE GAP: COSTS AND CONSEQUENCES IN 2007* ii (Aug. 2008), *available at* <http://www.kff.org/medicare/upload/7811.pdf>.

<sup>325</sup> *See id.*

<sup>326</sup> Kaiser Fam. Found., *Prescription Drug Benefit Under Medicare* (Oct. 2008), <http://www.kaiseredu.org/Issue-Modules/Prescription-Drug-Benefit-Under-Medicare/Background-Brief.aspx>.

<sup>327</sup> 42 U.S.C. § 1395kkk(g)(1)(A) (Supp. 2010).

<sup>328</sup> 42 U.S.C. § 1395kkk(g)(1)(E)(2) (Supp. 2010).

<sup>329</sup> *The Affordable Care Act—Implementation Timeline*, WHITEHOUSE.GOV, <http://www.whitehouse.gov/healthreform/timeline> (last visited Apr. 16, 2012).

<sup>330</sup> 42 U.S.C. § 1395kkk(m) (Supp. 2010).

The Board is tasked with reducing the per capita growth of Medicare spending.<sup>331</sup> When five-year Medicare costs are projected by the Centers for Medicare & Medicaid Services Chief Actuary to exceed a specified benchmark, the Board must propose a spending reduction.<sup>332</sup> The IPAB has been called, “the largest yielding of sovereignty from the Congress since the creation of the Federal Reserve.”<sup>333</sup>

The ACA directs the IPAB to propose, “as appropriate,” payment reductions to Medicare Part C and D—including direct subsidy to Part C and prescription plans under Part D.<sup>334</sup> Thus, the IPAB can address a major criticism of Part D: that Medicare was prohibited by law from using its market force to negotiate lower drug prices.<sup>335</sup> That IPAB can likely recommend that Medicare Part D plans receive rebates from drug manufacturers in accordance with state Medicaid programs.<sup>336</sup> And, though it is not certain, the IPAB may be able to recommend lower payment amounts for prescription drugs covered under Medicare Part B, and perhaps could establish a Medicare-operated Part D plan to compete with private drug plans.<sup>337</sup>

The IPAB is directed to propose denying high bids or removing high bids for prescription drug coverage from the “national average monthly bid amounts.”<sup>338</sup> But such proposals may not affect beneficiary premium percentages or the full premium subsidy.<sup>339</sup>

The ACA directs the Health and Human Services Secretary to implement IPAB proposals on August 15 of every year if Congress has taken no action.<sup>340</sup> Proposals take effect automatically, unless Congress enacts different cuts of the same amount, or the Senate votes by three-fifths majority to block or amend the proposal with a different savings amount.<sup>341</sup>

Beginning January 15, 2014, the Board may submit to Congress advisory reports on Medicare matters such as improvements to payment systems for services and suppliers (regardless of whether the Board submitted a proposal for that year).

The ACA expressly prohibits the IPAB from proposing recommendations that ration health care, raise revenues or Medicare beneficiary premiums, increase

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<sup>331</sup> 42 U.S.C. § 1395kkk(c)(8) (Supp. 2010).

<sup>332</sup> *Id.*

<sup>333</sup> Ezra Klein, *Can We Control Costs Without Congress?*, WASH. POST, Mar. 26, 2010, available at [http://voices.washingtonpost.com/ezraklein/2010/03/can\\_we\\_control\\_costs\\_without\\_c.html](http://voices.washingtonpost.com/ezraklein/2010/03/can_we_control_costs_without_c.html) (quoting Peter Orszag).

<sup>334</sup> 42 U.S.C. § 1395kkk(c)(2)(A) (Supp. 2010).

<sup>335</sup> See JACK EBELER ET AL., THE INDEPENDENT PAYMENT ADVISORY BOARD: A NEW APPROACH TO CONTROLLING MEDICARE SPENDING 10 (Apr. 2011), available at <http://www.kff.org/medicare/upload/8150.pdf>.

<sup>336</sup> See *id.* at 16.

<sup>337</sup> See *id.*

<sup>338</sup> See 42 U.S.C. § 1395kkk (Supp. 2010).

<sup>339</sup> See *id.*

<sup>340</sup> See *id.*

<sup>341</sup> See EBELER, *supra* note 335, at 11.

Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.<sup>342</sup> And before December 31, 2018, the IPAB is prohibited from proposing recommendations that reduce payment rates for items and services furnished prior to December 31, 2019.<sup>343</sup>

The consequences of repeal are twofold. In the short run, the funds and effort expended leading up to 2013 would be wasted. In the long term, the loss of a politically independent board empowered to enforce significant Medicare cost savings could affect the long term sustainability of Medicare. Of course, the nature of the IPAB makes it very difficult to evaluate the effects of what the board may or may not do in the future. But, given the difficulty of implementing cost containment measures in Medicare, the loss of a body at least empowered to reduce the costs would be significant.

#### *D. Taxes and Costs Savings*

##### 1. Federal Family Education Loan Program

As of June 30, 2010, the Reconciliation Act terminates the Federal Family Education Loan Program (FFELP).<sup>344</sup> It accomplishes this by inserting date restrictions on relevant statutory provisions. For example, 20 U.S.C. § 1071, which enables students to obtain loans from private lenders, now contains the following limiting language: “except that no sums may be expended after June 30, 2010, with respect to loans under this part for which the first disbursement is after such date.”<sup>345</sup>

The FFELP was an arrangement under which banks acted as middlemen for federally-guaranteed student loans. Under the FFELP, the federal government subsidized and guaranteed loans extended to students at qualifying educational institutions. If a borrower defaulted, a state agency or private nonprofit institutions guaranteed the loans, reimbursed the lender (or subsequent loan holder), and took title to the loan.<sup>346</sup> The government then reimbursed the guaranty agency and may have taken title to the loan.<sup>347</sup> The federal government received no benefit for this service, but intermediaries profited heavily.

The Congressional Budget Office estimated that from 2010–20, as a result of the repeal of the FFELP, the federal government would save \$40 billion that otherwise would have been given to banks just for servicing loans.<sup>348</sup> Banks and other intermediaries are the only beneficiaries, as students would receive the same loans on the same terms and the federal government guaranteed the loans anyway.

<sup>342</sup> See 42 U.S.C. § 1395kkk (Supp. 2010).

<sup>343</sup> See *id.*

<sup>344</sup> Health Care & Education Reconciliation Act of 2010, 20 U.S.C. § 1078 (Supp. 2010).

<sup>345</sup> 20 U.S.C. § 1071 (Supp. 2010).

<sup>346</sup> DONALD T. KRAMER, 2 LEG. RTS. CHILD. REV. 2D § 27:3 n.1.

<sup>347</sup> *Id.*

<sup>348</sup> Letter from Douglas W. Elmendorf, Director Congressional Budget Office, to Judd Gregg, Ranking Member Committee on the Budget U.S. Senate (Mar. 15, 2010), available at [www.cbo.gov/ftpdocs/113xx/doc11343/03-15-Student\\_Loan\\_Letter.pdf](http://www.cbo.gov/ftpdocs/113xx/doc11343/03-15-Student_Loan_Letter.pdf) [hereinafter Letter to Gregg].

Repealing the ACA could remove the date-limiting language and revive this wasteful program. It could add a significant financial burden back on the federal fisc. Still, it is notable that the January 19, 2010, House bill repealing the ACA, did not purport to repeal the Education reform provision of the Reconciliation act.<sup>349</sup> With respect to the Reconciliation Act, it applied only to “Health Care-Related Provisions.”<sup>350</sup> Subtitle A of the Reconciliation Act, which reforms student loans, was not included.<sup>351</sup>

We are not aware of any Republican presidential candidate who has, in pledging to repeal the ACA, expressed interested in maintaining this provision. However, if Congress revisits its previous repeal of the ACA, this provision would be unaffected by the repeal.

## 2. Unearned Income Tax and High Income Excise Tax

A largely overlooked but important and transformative provision of the ACA takes effect January 1, 2013, twenty days before the beginning of the 2013 presidential term. The ACA includes a number of new taxes, including taxes on medical devices, indoor tanning services, and certain high-cost insurance policies.<sup>352</sup> But the largest revenue generation comes from increasing the Medicare Hospital Insurance tax on high incomes and extending the tax to unearned income.<sup>353</sup>

In the tax year 2013, the ACA raises the Medicare payroll tax by .9% from 2.9% to 3.8%.<sup>354</sup> But the increase applies only to income over \$200,000 or \$250,000 for joint tax returns.<sup>355</sup> It also, for the first time, includes “unearned income” within the taxable amount.<sup>356</sup> Interest, dividends, annuities, royalties and some other capital gains will be taxable under the ACA.<sup>357</sup> But such unearned income is only taxed once income reaches \$200,000.<sup>358</sup>

The 3.8% also applies to the sale of property. Indeed an email circulated starting in 2010, claimed “if you sell your house after 2012 you will pay a 3.8% sales tax on it.”<sup>359</sup> However as with the current sale of other homes, the tax applies only to the

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<sup>349</sup> See *Repealing the Job-Killing Health Care Law Act*, H.R. 2, 112th Cong. (2011).

<sup>350</sup> *Id.*

<sup>351</sup> *See id.*

<sup>352</sup> Patient Protection & Affordable Care Act, 26 U.S.C. § 5000 (Supp. 2010); Health Care & Education Reconciliation Act of 2010, 26 U.S.C. §§ 3995, 4001 (Supp. 2010).

<sup>353</sup> JOINT COMM. ON TAXATION, ESTIMATED REVENUE EFFECTS OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4872, THE RECONCILIATION ACT OF 2010 2 (Mar. 20, 2010), available at <http://www.jct.gov/publications.html?func=startdown&id=3672>.

<sup>354</sup> Health Care & Education Reconciliation Act of 2010, 26 U.S.C. § 1411 (Supp. 2010).

<sup>355</sup> *Id.*

<sup>356</sup> *Id.*

<sup>357</sup> *Id.*

<sup>358</sup> *Id.*

<sup>359</sup> For a copy of the email, see *Real Estate Tax*, SNOPE.S.COM, <http://www.snopes.com/politics/taxes/realestate.asp> (last updated Mar. 15, 2012).



increase in basis. And the first \$500,000 is exempted for joint filers (\$250,000 for individuals).<sup>360</sup>

The increases in the Medicare Hospital insurance tax are projected to raise \$210 Billion from 2010 to 2019.<sup>361</sup> That revenue will be used to fund the massive expansion of Medicaid starting in 2014.

Because the tax provisions take effect only days before a potential repeal, the immediate effect of repeal would be minimal. But the long-term loss of several hundred billion dollars of revenue is significant. And by not expanding Medicaid coverage (paid for by the Medicare tax), roughly 16 million Americans would not gain coverage and the cost of treating these uninsured would continue to shift to other care payers.

Moreover, the political effects of a 2013 repeal may be significant if the loss of this provision is framed as a tax cut. As of this writing, there is growing anger directed at wealthy Americans perceived as paying a less than proportionate share of taxes. The Occupy Wall Street movement, the 99%ers movement, and questions raised about Mitt Romney's effective tax rate all appear to stem from this growing anger. Given that these tax increases target wealthy Americans, their loss through a repeal could be fairly characterized as a not-insignificant tax cut for those least in need of it.

#### V. CONCLUSION: WHAT THE COMBINED LOSS OF THESE PROVISIONS WOULD MEAN FOR AMERICA

Given the ACA's size and complexity, it is not surprising that the question of the consequences of a 2013 repeal yields a nuanced answer. Many, but not all, provisions discussed would have a significant impact if lost to a 2013 repeal. The loss of some provisions will have a greater effect than others on different swaths of the population. And if past is prologue, the provisions terminating the FFELP may not even be included in a repeal.

Somewhat paradoxically, for many of the neediest (those unable to afford basic comprehensive coverage), a 2013 repeal may not dramatically affect their condition—though repeal after 2014 would significantly impact this group. The neediest, if covered, are likely to have inexpensive plans that are waived from annual limit restrictions prior to 2014. The neediest are also unlikely to have insurance offering dependent coverage, such that the extension of coverage for depended adults would provide a real benefit. Similarly, they may not benefit from the protection for children with preexisting conditions because insurers have the option (if allowed by state law) to charge more to cover children with preexisting conditions—thus making coverage unaffordable.

Still, certain ACA provisions will help the neediest, provided they have some form of insurance, and thus would be disruptive if repealed. The ban on rescission is particularly helpful to those who purchase individual coverage—lower-income individuals tend not to have employer-based coverage. And the expansion of preventive care and medical loss ratios ensures greater value for those with coverage. Moreover, the small business tax credit (though relatively limited in takeup) no doubt has resulted in coverage for some needy.

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<sup>360</sup> *Publication 523: Selling Your Home*, U.S. DEP'T OF THE TREASURY: INTERNAL REVENUE SERV. (Jan. 23, 2012), available at <http://www.irs.gov/pub/irs-pdf/p523.pdf>.

<sup>361</sup> JOINT COMM. ON TAXATION, *supra* note 353, at 2.

This is not to say that the ACA will not significantly aid the needy. Indeed the needy arguably benefit from the ACA more than any other group. In particular, the Medicaid expansion and tax credits to buy coverage will cover millions of uninsured, low-income Americans. But these changes begin in 2014. Thus, a repeal after 2014 would be more devastating to needy Americans than a 2013 repeal.

Yet, for many Americans who have coverage, the loss of the protections provided by the ACA in early 2013 would be significant. The ban on lifetime limits and restrictions on annual limits provide critical protection for many insureds. By the time of repeal, an affected plan will not be permitted to impose an annual limit below \$2,000,000. Moreover, the 2.5 million young Americans gaining coverage under the extension of dependent coverage clearly demonstrates the wide appeal of this provision. And the medical loss ratio requirement ensures that Americans able to afford coverage get value for their premium dollars. Finally, the expansion of preventive coverage will help incentivize Americans to obtain regular checkups and immunizations and avoid more costly remedial care down the road.

For Medicare recipients, the ACA, now and in 2013, provides a panoply of benefits. The closing of the donut hole is removing a significant threat to the financial health of older Americans. The expansion of preventive coverage will similarly encourage better health without penalizing Medicare enrollees. Perhaps most significantly, the costs savings such as reducing the Medicare Advantage overpayment, and those stemming from providing better preventive care will help ensure the long term financial viability of the Medicare Program.

Similarly, a 2013 repeal will reach all Americans through its effect on the federal fisc, in the form of savings lost or funds expended in vain. Significant expense has already been incurred (and will continue to be incurred leading up to 2013) in setting up the state-based exchanges and implementing the regulatory work behind provisions taking effect before the next presidential term. The incurred cost would not be refunded if the ACA is repealed. The savings enjoyed by the Medicare program would evaporate, putting the future of the Medicare program in question. Additionally, the FFELP could conceivably be reinstated. Under Congressional Budget Office estimates, this would result in the loss of \$40 billion in savings from 2010–20.<sup>362</sup>

Given the importance of these provisions, it is not hyperbole to say that taken together, these losses could cause millions of individuals who now have health coverage to lose that coverage. Particularly, the provisions relating to the extension of dependent care, restrictions on annual limits, small business tax credits, and closing of the donut hole make the difference between insured or uninsured for millions of Americans. Moreover, the improvements starting in 2014 will cover significantly more Americans. The CBO estimates that if the ACA is repealed, 33 million fewer nonelderly people would have health insurance in 2021.<sup>363</sup>

The 2012 election is shaping up to be a referendum on Health Care Reform. The ACA is admittedly a complicated pair of bills. Few Americans have a good handle on the substance of the ACA. Those wishing to repeal the ACA certainly have not attempted to explain the ACA's contents to voters, instead largely relying on

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<sup>362</sup> Letter to Gregg, *supra* note 348, at 4.

<sup>363</sup> Letter from Douglas W. Elmendorf, Director Congressional Budget Office, to John Boehner, Speaker of the House (Feb. 18, 2011), *available at* <http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf>.

generalities: “It’s bad law. It’s bad constitutional law. It’s bad medicine.”<sup>364</sup> Politicians who support the ACA can also be fairly criticized for not doing everything possible to explain the benefits in the ACA.

Lost in the sound bites of White House aspirants who hope to score political points by deriding the ACA for creating a “government takeover of healthcare,” is the market-based approach that already has provided very real benefits to individuals who previously lacked health insurance coverage, or who had coverage so limited that it left them effectively uninsured when they needed it most. In the two years since the ACA’s passage, it has benefited millions and set the country on a path to improved health outcomes. Although not without its flaws, the ACA has accomplished much to begin achieving its goal of near-universal coverage while saving taxpayer dollars. Regardless of one’s political bent, we hope that the ACA’s benefits are not ignored.

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<sup>364</sup> Andrew Malcolm, *The Ames Republican Debate Transcript: Everything They Said That You Missed*, L.A. TIMES, Aug. 13, 2011, available at <http://latimesblogs.latimes.com/washington/2011/08/ames-debate-romney-bachmann-paul-huntsman-santorum-gingrich-pawlenty-cain.html> (quoting Mitt Romney).