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Health Care Reform: What Has Been Accomplished? What Comes Next?

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Enactment of the Patient Protection and Affordable Care Act (ACA) in 2010 marked the most important accomplishment in U.S. health care reform in decades. Not since Medicare and Medicaid were passed in 1965 have so many Americans been given access to insurance coverage for their health care. Though the goal of universal health care was not achieved, ACA brought coverage to millions of uninsured Americans and provided assurance to the already-insured that if they lost their insurance through job loss or job change, they could turn to an expanded Medicaid program or a government-subsidized insurance policy for affordable coverage.

But while ACA has had a major impact on the U.S. health care system, its promise has been limited by its design. Rather than replacing the U.S. system with a more effective, less costly, and politically sustainable model, lawmakers decided to build on top of an inefficient, expensive, and politically insecure, existing model. A health care system that rested on a shaky foundation now has to carry more weight and that makes for an unstable future. Indeed, we are already starting to see some unraveling of ACA. For ACA to achieve its goals in a durable fashion, it should be replaced by a health care program that provides the same kind of health care coverage for all Americans rather than relying on a system that mixes employer-based insurance with individually-purchased private insurance and government-provided coverage.

ACA AND ACCESS

As indicated, ACA has done much in terms of its key goal to expand access to care. Around twenty million previously uninsured Americans have gained coverage,¹ and tens of millions more Americans know that ACA's provisions will protect them if they ever lose their employer-sponsored

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1. Robin A. Cohen, Emily P. Zammitti, & Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016*, NATIONAL CENTER FOR HEALTH STATISTICS (May 2017), available at <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf>. Trump Administration policies may be eroding some of the gains. Abby Goodnough, *Health Law Sign-Ups Fall Slightly After Cuts*, N.Y. TIMES, Apr. 3, 2018, at A20.

insurance or can no longer afford their individually-purchased health care insurance.

But rather than expanding coverage through adoption of a single-payer, “Medicare-for-all” kind of program, ACA improved coverage by reducing the barriers to access that kept nearly fifty million Americans out of the pre-ACA health care system.² Many more Americans are covered now, and they receive coverage very similar to what the previously-insured had already been receiving. It’s essentially the same old health care house with the doors opened wider rather than a new health care house.

Consider, for example, how Medicaid has become more accessible to the indigent. While Medicaid was adopted in 1965 to provide health care coverage for the poor, it never really tried to cover all of the poor. Rather, it was structured to cover the so-called “deserving poor.”³ To qualify for pre-ACA Medicaid, being poor was necessary but not sufficient. One had to be poor and something else—poor and disabled, poor and a child, poor and pregnant, or poor and a single caretaker of a child.⁴ Moreover, the definition of poor could be quite limited, with each state setting its own standard. In Massachusetts, a parent could earn up to 133% of the federal poverty level and still qualify for Medicaid, while a working Texas parent lost eligibility once family income exceeded 26% of the federal poverty level.⁵

Under ACA, eligibility requirements for Medicaid have been relaxed, and in two important ways. First, one now qualifies for Medicaid simply by being poor.⁶ One does not have to be disabled, pregnant, a child, or a caretaker of children to receive Medicaid benefit. Now, poor adults who are able-bodied and childless are eligible for health care coverage under ACA’s Medicaid expansion.⁷

Second, ACA provides a uniform definition of poverty for purposes of health care coverage.⁸ Under ACA, anyone with a family income up to 138% of the federal poverty level can qualify for Medicaid coverage.⁹ For an

2. Barack Obama, *United States Health Care Reform Progress to Date and Next Steps*, 316 JAMA 525 (2016).

3. David Orentlicher, *Rights to Health Care in the United States: Inherently Unstable*, 38 AM. J. L. & MED. 326, 329 (2012).

4. *Id.* at 331.

5. Council of State Gov’ts, *Capitol Facts and Figures: Medicaid and CHIP Eligibility—Update*, 2011 CAP. FACTS AND FIGURES 1, 3 (Jan. 2011), https://knowledgecenter.csg.org/kc/system/files/Medicaid_and_CHIP_Eligibility_Update_1.pdf. Jobless parents in Texas lost Medicaid benefits once their family income exceeded twelve percent of the federal poverty level. *Id.*

6. David Orentlicher, *Medicaid at 50: No Longer Limited to the “Deserving” Poor?*, 15 YALE J. HEALTH POL’Y L. & ETHICS 185, 186 (2015).

7. *Id.* at 186. Some states did expand their Medicaid programs before ACA to include poor adults who were healthy and childless. *Id.*

8. *Id.*

9. *Id.*

individual, that is about \$16,750 a year; for a family of four, about \$34,640.¹⁰ In other words, ACA was designed to ensure that a poor person's access to health care coverage would not depend on the state in which the person lived. Being poor in Mississippi should not result in less access to coverage than being poor in Minnesota.

To be sure, in *National Federation of Independent Business v. Sebelius*,¹¹ the Supreme Court held that states must be able to choose whether to participate in the Medicaid expansion,¹² so differences from state to state still exist. A non-expansion state can set its income cut-off well below 138% of the federal poverty level, with Texas and Alabama coming in the lowest, at 18% of the federal poverty level for parents.¹³ But those differences are likely temporary. With the federal government picking up ninety percent of the costs of the Medicaid expansion, all states are likely to sign on ultimately. Indeed, it took seventeen years for every state to sign onto the original Medicaid program.¹⁴

In addition to opening the health care system's doors to many more poor Americans, ACA opened the door to non-poor Americans who do not receive health care coverage from an employer and who cannot afford coverage on their own.¹⁵ The high cost of health care makes coverage unaffordable for many low- and middle-income Americans—earning more than 138% of the federal poverty level may make one non-poor, but it does not necessarily make one wealthy enough to pay for health care insurance. For a couple earning 150% of the federal poverty level, or \$37,650, there are not enough dollars to afford the \$10,000 premium for a family health insurance policy.¹⁶ And for those Americans with a history of diabetes, heart disease, or other “pre-existing conditions,” health care premiums were especially unaffordable before ACA. Health insurers would increase the cost of policies by two-fold or more or refuse to sell a policy at all.¹⁷

ACA addresses the access problems for the non-poor in a few key ways. First, insurers no longer can charge people more because of their health care

10. These figures are based on 2018 federal poverty guidelines. Office of the Assistant Sec'y for Planning and Evaluation, U.S. *Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs*, U.S. DEP'T HEALTH & HUMAN SERVS., <https://aspe.hhs.gov/poverty-guidelines>.

11. 567 U.S. 519 (2012).

12. *Id.* at 585-88.

13. *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults*, HENRY J. KAISER FAM. FOUND. 9 (March 2018), at <http://files.kff.org/attachment/Fact-Sheet-Where-are-States-Today-Medicaid-and-CHIP-Eligibility-Levels-for-Children-Pregnant-Women-and-Adults>.

14. Arizona was the last state to adopt a Medicaid program, doing so in 1982. Charles Brecher, *Medicaid Comes to Arizona: A First-Year Report on AHCCCS*, 9 J. HEALTH POL., POL'Y & L. 411 (1984).

15. Orentlicher, *supra* note 6, at 190.

16. See Office of the Assistant Sec'y for Planning and Evaluation, *supra* note 10.

17. Orentlicher, *supra* note 6, at 191.

status.¹⁸ The person with diabetes or heart disease pays the same amount for their health care as the healthy person (“community rating”).¹⁹ In addition, insurers cannot try to evade the requirement of community rating by refusing to sell a policy to a patient who has a preexisting condition (“guaranteed issue”).²⁰ Finally, for non-poor Americans who cannot afford the cost of a health care policy, ACA provides subsidies for the purchase of a policy.²¹ People earning 150% of the federal poverty level might only pay 10% of the cost of their coverage, while people earning 350% of the federal poverty level might pay 50-60% of the cost of their coverage.²²

In sum, ACA was designed to make one’s locale, income, or health much less important for access to health care. Under ACA’s Medicaid expansion, the poor in Arkansas have the same access to health care as the poor in Massachusetts.²³ Similarly, the person with a history of diabetes or heart disease has the same access to care as the healthy person. And with the ACA subsidies, one does not need to be poor to receive help in purchasing health insurance. Between its expansion of Medicaid and its reforms of the private market for health care coverage, ACA has brought health care coverage to twenty million Americans, about sixty percent through Medicaid and forty percent through the purchase of private insurance.²⁴ In terms of getting health care coverage to the uninsured, ACA has been quite successful.

ACA AND HEALTH

While increasing access to health insurance is an important goal, it is important not for its own sake. Rather, access to coverage is important for its role in promoting better health. Uninsured persons are sicker than insured persons, and they have a shorter life expectancy.²⁵ By providing health insurance to millions of Americans, ACA should make for a healthier public.

Does it? The answer is not as clear as one might think. Further discussion on this point follows in the next section.

18. Molly Frean, Jonathan Gruber, & Benjamin Sommers, *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, 53 J. HEALTH ECON. 72, 87 (2017).

19. *Id.*

20. *Nat’l. Fed’n. of Indep. Bus.*, 567 U.S. at 547-48. ACA’s individual mandate to purchase insurance was included to prevent patients from gaming the new health care system. If insurers had to accept all comers and charge them the same premium, some people might wait until they become sick to buy their health care insurance. *Id.* at 548.

21. *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015).

22. See *Health Insurance Marketplace Calculator*, HENRY J. KAISER FAM. FOUND. (Nov. 3, 2017), <https://www.kff.org/interactive/subsidy-calculator/>.

23. To be sure, for residents of non-expansion states, it still matters how poor they are.

24. Frean et al., *supra* note 18, at 83.

25. John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061, 2061 (2000)

Other benefits of expanded coverage are more certain. For example, it is clear that improving access to health coverage improves access to health care. Insured persons are more likely to see a physician when sick, more likely to fill a prescription for medication, and more likely to receive surgical care.²⁶ In one study, researchers compared two states (Arkansas and Kentucky) that had signed on to ACA's Medicaid expansion with one state (Texas) that did not expand its Medicaid program. People in Arkansas and Kentucky were more likely to receive regular care for chronic medical conditions and less likely to skip medications because of their cost.²⁷

Moreover, giving the uninsured health care coverage provides clear financial benefits. When comparing patients in Arkansas and Kentucky with those in Texas, researchers found that the Arkansas and Kentucky patients experienced less trouble paying their medical bills.²⁸ Similarly, in its first ten years of operation, Medicare delivered major financial relief to its recipients. For beneficiaries who had paid the most in out-of-pocket medical spending before Medicare was adopted, the introduction of the program was associated with a forty percent decline in out-of-pocket spending.²⁹

But do the newly-insured have better health to go along with their increase in health care and decrease in financial stress? That is exactly what several studies demonstrate.³⁰ But other studies have not found that providing health care coverage improves the health of the previously uninsured.³¹ How much ACA will improve the health of Americans is not as clear as one might expect.

Studies finding that health care coverage improves health

When researchers have looked at some expansions of health care coverage similar to the expansions under ACA, they have found that the expansions were followed by important gains in health. For example, in 2006, Massachusetts enacted statewide ACA-like health care reform that included an individual mandate to carry health care coverage and an expansion of the state's Medicaid program.³² Researchers compared rates of

26. Benjamin D. Sommers, Atul A. Gawande, & Katherine Baicker, *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586, 587 (2017).

27. Benjamin D. Sommers, Robert J. Blendon, & E. John Orav, *Both The 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults*, 35 HEALTH AFF. 96 (2016). Interestingly, it was more important whether a state expanded its Medicaid program than whether it did so through a traditional Medicaid program or a private coverage option. *Id.* at 104.

28. *Id.* at 99.

29. Amy Finkelstein & Robin McKnight, *What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending*, 92 J. PUB. ECON. 1644, 1658 (2008).

30. Katherine Baicker et al., *The Oregon Experiment: Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 14 (2013).

31. *Id.*

32. Obama, *supra* note 2.

death in fourteen Massachusetts counties with mortality rates in 513 demographically-similar counties in forty-six other states.³³ Compared to the counties in other states, the Massachusetts counties had a mortality rate about three percent lower.³⁴ Two other data points also suggested that the lower death rates resulted from health care reform. First, the declines in death rates were greater in the counties that had higher rates of uninsured residents before the reform.³⁵ Second, the death rate was especially lower for “health-care amenable mortality.” That is, for illnesses for which medical intervention is more likely to make a difference, as with heart disease, stroke, cancer, and infections, the mortality rate was 4.5 percent lower in the Massachusetts counties.³⁶

Or consider other expansions of health care coverage that preceded ACA. Recall that pre-ACA Medicaid covered able-bodied adults only if there were children in the household. Before the enactment of ACA, some states had done their own partial expansions of Medicaid by extending coverage to childless adults.³⁷ In an important study, researchers compared three of these expansion states with neighboring states that did not extend coverage to childless adults. The expansions took place between 2000 and 2005, and they were followed by a significant reduction in mortality rates over the next five years.³⁸ More specifically, the expansion states saw a six percent reduction in their death rates compared to the non-expansion states.³⁹

Early data from ACA also indicate important health benefits. For example, ACA prohibits “cost-sharing” for recommended preventive care.⁴⁰ Insurers must cover the full cost of flu shots, mammograms, colonoscopies, blood tests for prostate cancer, and similar care without requiring the patient to pay part of the costs.⁴¹ Since this provision of ACA took effect, there has been an increase in the detection of early-stage colon cancers among Medicare patients.⁴² Removing the financial barriers to colon cancer screening appears to have encouraged more Medicare recipients to seek timely care.

33. Benjamin D. Sommers, Sharon K. Long, & Katherine Baicker, *Changes in Mortality after Massachusetts Health Care Reform: A Quasi-experimental Study*, 160 *Annals Intern. Med.* 585 (2014).

34. *Id.* at 590.

35. *Id.* at 591.

36. *Id.* at 586, 589.

37. Benjamin D. Sommers, Katherine Baicker, and Arnold M. Epstein, *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 *NEW ENG. J. MED.* 1025, 1026 (2012).

38. *Id.* at 1028.

39. *Id.*

40. 29 C.F.R. § 2590.715-2713 (2017).

41. *Id.*

42. Brett Lissenden & Nengliang “Aaron” Yao, *Affordable Care Act Changes to Medicare Led to Increased Diagnoses of Early-Stage Colorectal Cancer Among Seniors*, 36 *HEALTH AFF.* 101 (2017).

Studies not finding a health benefit from increased access to coverage

While the studies finding a health benefit from health care coverage are impressive, so are the studies finding little or no health benefit from increased access to coverage. For example, the life expectancy of lower-income persons is not correlated with the amount of health care that they receive, nor do their mortality rates change when they become eligible for Medicare.⁴³ Similarly, in a study that reviewed the health impact of Medicare during its first ten years of operation, researchers found no discernible impact of Medicare on death rates of seniors.⁴⁴

While the early impact of Medicare might have been limited because it predated important advances in medical care,⁴⁵ such as statins to lower cholesterol, a study on the later impact of Medicare came to a similar conclusion. Researchers looked at people nationwide who were age fifty to sixty-one in 1992 and followed their health care use and health outcomes for the next eighteen years.⁴⁶ They found that insured individuals used more health care resources than did the uninsured, but they found no evidence that being insured lowered the risk of death fourteen years into the study and only mild evidence of a mortality benefit at sixteen to twenty years.⁴⁷

As the study authors observed, even the mild benefit may have reflected unmeasured factors (e.g., diet or exercise habits) rather than health insurance status.⁴⁸ By sixteen to eighteen years into the study, everyone would have become a Medicare recipient, and many of the study subjects would have become Medicare eligible much earlier. Indeed, the oldest study subjects would have spent fourteen out of their eighteen study years on Medicare. One would expect risk of death to have declined rather than increased once the uninsured persons became insured under Medicare, but their mortality rate rose only after they enrolled in Medicare.

Why might having Medicare not improve health for the previously uninsured? As discussed, having insurance makes for more health care,⁴⁹ but

43. See Raj Chetty et al., *The Association between Income and Life Expectancy in the United States, 2001-2014*, 315 JAMA 1750, 1763 (2016).

44. Finkelstein & McKnight, *supra* note 29, at 1650. It's possible that this study says more about the benefits of health insurance rather than the benefits of health care. Uninsured seniors may generally have sought care for illnesses that could be treated effectively, regardless of their insurance status. *Id.* at 1650-53. While the researchers saw limited benefits for the physical health of Medicare recipients, they found striking benefits for the financial health of Medicare beneficiaries. See *id.* at 1650.

45. *Id.* at 1665-66.

46. Bernard Black et al., *The Long-term Effect of Health Insurance on Near-Elderly Health and Mortality*, 3 AM. J. HEALTH ECON. 281, 283 (2017).

47. *Id.* at 284. The studied age group was chosen because younger persons are generally healthier and therefore not in great need of health care, and older persons would receive health care via Medicare. *Id.* at 281.

48. *Id.* at 284.

49. See *supra* p. 5-6.

more health care can be harmful. Also, lacking health care coverage need not mean lack of access to critically important care. The uninsured can receive emergency care at hospitals and non-urgent care at public clinics.⁵⁰

Consider as well a study that measured the impact of health care on health after a lottery for uninsured persons in Oregon gave some of them access to Medicaid coverage.⁵¹ By using a lottery to decide access, Oregon effectively created a randomized controlled study of the benefits of health care coverage. Applicants who won the lottery and enrolled in Medicaid could be compared with applicants who lost the lottery and remained uninsured. Two years after enrollment in Medicaid, the lottery winners received more health care than their uninsured counterparts, and they reported less financial strain, but they experienced no reduction in levels of hypertension, high cholesterol, or diabetes.⁵²

Another study based on random assignment between coverage and no coverage found similar results.⁵³ This study involved persons who received Social Security benefits on account of disability. After two-three years, the coverage group reported better access to health care and better health status, but there were only small objective improvements in health and no difference in mortality between the two groups.⁵⁴

How do we reconcile the conflicting studies? We might give greater weight to the studies that had random assignment between coverage and no coverage since those studies were better controlled for other factors that might influence a person's health. On the other hand, those studies were smaller and ran for shorter periods of time so were less tailored to identify differences in outcome. Moreover, the patients in those studies reported subjective improvements in health status (i.e., they felt healthier), and subjective improvements in health are associated with a decrease in mortality rates.⁵⁵ One important consideration in the lack of clarity may be that when it comes to a person's health, health care is probably much less important than genetics, diet, environment, and public health programs.⁵⁶

50. Black et al., *supra* note 46, at 304-05. See also Finkelstein & McKnight, *supra* note 29.

51. Oregon was able to enroll 10,000 uninsured persons into its Medicaid program, and 90,000 people met the eligibility requirements to be enrolled. Katherine Baicker et al., *supra* note 30, at 1714.

52. *Id.* at 1718-19.

53. Robert R. Weathers II and Michelle Stegma, *The Effect of Expanding Access to Health Insurance on the Health and Mortality of Social Security Disability Insurance Beneficiaries*, 31 J. HEALTH ECON. 863, 867-68 (2012).

54. *Id.* at 863.

55. Sommers et al., *supra* note 33, at 589.

56. Steven A. Schroeder, *We Can Do Better—Improving the Health of the American People*, 357 NEW ENG. J. MED. 1221, 1222 (2007).

ACA AND THE COSTS OF HEALTHCARE

Advocates for ACA promised not only greater access to health care but also less costly care. ACA was supposed to “bend the cost curve.”⁵⁷ There is some evidence that ACA has moderated health care cost inflation. For example, the cost of employer-provided coverage went up three to four percent in 2017,⁵⁸ an amount well below the double digit increases in premium costs during the late 1980’s and early 1990’s.⁵⁹

On the other hand, health insurance premium increases had started to moderate before ACA took effect, and other factors may have been more important. For example, health insurance plans have raised their deductibles and co-payments to discourage overutilization of the health care system by patients, and that has slowed the increase in premium costs.⁶⁰ In addition, the sluggish economy that has followed the Great Recession of 2008 also moderated health care costs, as fewer people had access to health insurance.⁶¹

When one looks more broadly than health insurance premiums at the total amount of spending on health care in the United States, there is no clear, long-term impact from ACA. In the early to mid-2000s, health care costs increased at a rate of 6.5-9.5% but dropped to a three to four percent rate of increase following the Great Recession in 2008.⁶² There was a bump in 2014 and 2015 to a health care cost inflation rate of five to six percent,⁶³ but that reflected ACA’s increase in access to health care coverage.

WHAT COMES NEXT?

Even proponents of ACA saw it as a work in progress. Political considerations led congressional Democrats to rush ACA’s enactment before refining the legislative language. Moreover, political differences led to many compromises that were distasteful to people on both sides of the health care

57. Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601 (2010).

58. Gary Claxton et al., *Health Benefits in 2017: Stable Coverage, Workers Faced Considerable Variation in Costs*, 36 HEALTH AFF. 1838, 1839 (2017). Premiums rose four percent for individual plans and three percent for family plans. *Id.*

59. Cynthia B. Sullivan et al., *Employer-Sponsored Health Insurance in 1991*, 11(4) HEALTH AFF. 172, 178 (1992).

60. Anne B. Martin et al., *National Health Spending In 2012: Rate Of Health Spending Growth Remained Low For The Fourth Consecutive Year*, 33 HEALTH AFF. 67, 70 (2014). Of course, people may be paying less in premiums but more in deductibles and co-payments. Also, raising deductibles and co-payments can too greatly discourage sick people from seeking care and therefore worsen health overall. David Orentlicher, *Controlling Health Care Spending: More Patient “Skin in the Game?”*, 13 IND. HEALTH L. REV. 348, 354 (2016).

61. Martin et al., *supra* note 60, at 74.

62. Centers for Medicare & Medicaid Services, *National Health Expenditure Tables*, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last visited Jul. 9, 2018).

63. *Id.*

reform debate. Advocates hoped to extend ACA in subsequent years, perhaps to adoption of a single-payer, “Medicare-for-All” kind of system. Opponents, on the other hand, hoped to repeal ACA, or at least cut its reach back.

The 2016 elections gave opponents of ACA the upper hand, and they have used it to degrade ACA. Most importantly, as part of the 2017 tax reform, Congress repealed ACA’s penalty for people who do not carry health care coverage. The mandate to purchase insurance still remains, but the tax penalties are gone.⁶⁴ That could reduce the number of insured Americans by an estimated four million people in the short term and thirteen million by 2027.⁶⁵

Some research suggests that these estimates may be too high,⁶⁶ and an important question with respect to the different estimates is what role public perceptions have played. That is, with all of the media attention to the mandate to purchase insurance, many people may have assumed they were subject to the mandate even when they were exempted. Thus, for example, much of the increased Medicaid enrollment occurred among people who were eligible under pre-ACA Medicaid but had not signed up.⁶⁷ Even though they were not subject to the mandate because of their low income, they may have thought they were. With the repeal of the mandate penalty, public perceptions may shift toward the view that the obligation to carry insurance is gone, and fewer people may renew their coverage or sign up for the first time.⁶⁸

The repeal of the mandate penalty also may increase the cost of health insurance for those who remain in the health care insurance market. Many young, healthy Americans will recognize that ACA’s requirement of community rating means that health care insurance premiums include a subsidy for less healthy persons that is paid by healthier persons. In other words, young, healthy people do not get their money’s worth when they buy health insurance,⁶⁹ while older, sicker people get more than their money’s worth. Some of the young, healthy will reject what seems like a bad deal for them and decide against buying health care coverage. With a remaining

64. John Hsu et al., *Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums*, HEALTH AFF. BLOG (Mar. 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180223.551552/full/>.

65. Susan Yeh Beyer et al., *Repealing the Individual Health Insurance Mandate: An Updated Estimate* CONGRESSIONAL BUDGET OFFICE 1 (2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf>.

66. According to a careful analysis of ACA’s increase in access to coverage, the mandate penalties have not played a significant role. Rather, what seems to have driven increased access are the Medicaid expansion and the subsidies for the purchase of insurance. Frea, Gruber, & Sommers., *supra* note 18, at 83-84.

67. *Id.* at 83.

68. Of course, that should be less true among new Medicaid recipients than among new purchasers of private insurance policies since the Medicaid recipients do not pay premiums for their coverage.

69. To be sure, in the long run, young people will get their money’s worth. They may “overpay” while young, but they will “underpay” when older.

group of purchasers who are less healthy on average, premiums will rise. According to an analysis for California, the repeal of the mandate penalty will increase premiums between five and nine percent.⁷⁰

Other policies adopted by the Trump Administration could lead to further weakening of the health insurance market for less healthy persons. For example, businesses are now allowed to form group “association” plans to obtain health coverage for their employees.⁷¹ One way to obtain less expensive association plans is by forming groups with relatively healthy employees.⁷² As with the departure of young, healthy individuals from the standard market, the departure of groups of healthy workers will cause premiums to rise for the people remaining in the standard market for health care insurance.⁷³

With its repeal of the mandate penalties, its permission for association plans, and other policies,⁷⁴ the Trump Administration is re-splitting the market for health care coverage that ACA had tried to unify. By bringing all purchasers of insurance into a single pool, ACA could ensure that everyone would pay an affordable premium rather than having some people pay a low premium and other people pay a high premium. The revisions to ACA allow insurers to stratify their customers into different premium levels.⁷⁵

The Trump Administration has adopted other policies that will erode the impact of ACA. For example, the administration has ended the government’s funding for the “cost-sharing reduction” subsidies that complement ACA’s premium subsidies.⁷⁶ As discussed, ACA helps low- and middle-income persons afford the purchase of health care insurance by subsidizing the costs of the insurance premiums.⁷⁷ ACA also helps with affordability by providing subsidies for the additional cost-sharing features of health care insurance,

70. Hsu et al., *supra* note 64.

71. Robert Pear, *New Trump Rule Rolls Back Protections of the Affordable Care Act*, N.Y. TIMES, June 19, 2018, at A11.

72. *Id.* It’s not clear whether the administration’s policy on association plans allow for distinctions on the basis of health. *Id.*

73. Katie Keith, *Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans*, HEALTH AFF. BLOG (June 21, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180621.671483/full/>.

74. For example, the Trump Administration has proposed an expansion of the market for low-cost, low-benefit plans. *Should States Allow Insurers to Offer Bare-Bones Health Plans with Fewer Mandated Benefits?*, WALL ST. J., June 25, 2018.

75. Rabah Kamal et al., *Tracking 2019 Premium Changes on ACA Exchanges*, HENRY J. KAISER FAM. FOUND. (Jun. 29, 2018), <https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/>.

76. Rabah Kamal et al., *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums*, HENRY J. KAISER FAM. FOUND., (Oct. 27, 2017), <http://files.kff.org/attachment/Issue-Brief-How-the-Loss-of-Cost-Sharing-Subsidy-Payments-is-Affecting-2018-Premiums>.

77. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, HENRY J. KAISER FAM. FOUND. (Nov. 08, 2017), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>.

such as deductibles and co-payments.⁷⁸ But while funding for the premium subsidies kicks in automatically, a quirk in the text of ACA suggests that Congress has to reauthorize funding for the cost-sharing subsidies every year.⁷⁹ The Obama Administration took the position that the cost-sharing subsidies also were automatic, but the Trump Administration rejected that interpretation and concluded that only Congress had the power to authorize the subsidies.⁸⁰ With Republican control of Congress, the funding has not been reauthorized.⁸¹

All of this is not to say that lower income Americans have lost their cost-sharing reductions. Insurance companies still must implement the reductions, but the federal government no longer provides reimbursements for the reductions.⁸² As a result, insurers are charging higher premiums to recoup the lost funding.⁸³ With this shifting of costs to premiums, premium subsidies will go up to compensate, but those who purchase their own policies and do not qualify for premium subsidies may find it increasingly difficult to afford coverage.

Ironically, some changes designed to reduce coverage may actually lead to increases in coverage, at least in the short term. The Medicaid expansion changes are particularly important in this regard. The Trump Administration has given states more flexibility in how it administers the Medicaid expansion, such as by allowing work requirements for Medicaid recipients.⁸⁴ While most Medicaid recipients will be able to satisfy the work requirements, not all will, so the work requirements may limit the impact of the Medicaid expansions on access to health care coverage.

But this decrease in coverage may be offset by other increases in coverage. The option of work requirements may entice non-expansion states to participate in the Medicaid expansion. If states such as Florida, Georgia, and Texas sign onto the expansion, the number of insured will go up overall, even if it will not go up as much as it could.

Of course, over the long term, there will be an overall decrease in enrollment. Eventually, as with original Medicaid, all states likely will sign on to the expansion. Having all states sign on with no work requirements is better in terms of enrollment than having some states sign on with work requirements.

78. *Id.*

79. *See* U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 169-70 (D. D.C. 2016).

80. Thomas Kaplan & Robert Pear, *End of Health Care Subsidies Puts Congress in a Tight Spot*, N.Y. TIMES, Oct. 13, 2017, at A1.

81. Rabah Kamal et al., *supra* note 76.

82. *Id.*

83. Kaplan & Pear, *supra* note 80, at A1.

84. Benjamin D. Sommers et al., *New Approaches in Medicaid: Work Requirements, Health Savings Accounts, and Health Care Access*, 37 HEALTH AFF. 1, 3 (Apr. 23, 2018).

WHAT SHOULD BE GOING ON?

As mentioned, even proponents of ACA have recognized that it needs refinement to fulfill its goal of access to affordable health care for all Americans. Several measures would make for a more effective ACA:

1. A commitment by Congress to pay the cost-sharing reductions that are provided by insurance companies to lower-income Americans. U.S. Senators Patty Murray and Lamar Alexander have drafted a bipartisan bill to ensure funding for the reductions, but it has not garnered sufficient support yet.⁸⁵
2. Reinstatement of “reinsurance” for insurers with very high claims. ACA included a temporary reinsurance provision, under which the federal government would share the costs of patients who incurred very high health care costs.⁸⁶ With the government picking up some of the costs, insurers had lower costs and more predictable costs. The two factors together allowed insurers to set premiums at a lower level. A few states, including Minnesota and Alaska, have adopted their own reinsurance plans, with insurance premiums coming in as much as 20 percent lower.⁸⁷ A nationwide reinsurance program would provide financial relief for many more Americans, and its costs would be partially offset since lower premiums would reduce the amount needed for the premium subsidies paid by the federal government.
3. Restoration of the penalties for the mandate to carry health insurance coverage. As the U.S. Supreme Court recognized in *NFIB v. Sebelius*, the mandate to carry insurance is a key component of ACA.⁸⁸ Once insurers are prohibited from including “pre-existing conditions” clauses in their policies and are subject to guaranteed issue and community rating rules, the mandate to carry insurance prevents people from trying to exploit ACA’s protections by waiting until they are sick to buy their health insurance policies. In other words, the individual mandate is a matter of fairness. Just as we do not let people wait until their houses are on fire to buy their

85. Timothy Stoltzfus Jost, *Market Stabilization Stalls; States Step In*, 37 HEALTH AFF. 848, 848 (2017).

86. Cynthia Cox et al., *Explaining Health Care Reform: Risk Adjustment, Reinsurance and Risk Corridors*, HENRY J. KASIER FAM. FOUND. (Aug. 17, 2016) <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.

87. Robert Pear, *Minnesota Finds a Way to Slow Soaring Health Premiums*, N.Y. TIMES, Sept. 2, 2017, at A14.

88. *Nat’l. Fed’n. Indep. Bus.*, 567 U.S. at 539.

homeowners' insurance, so we should not let people wait until they are sick to buy their health insurance.

4. Taking greater steps to promote cost containment. ACA includes many pilot programs for cost containment, such as “bundled payments” for hospital care and financial incentives to form efficient “accountable care organizations,”⁸⁹ but it is not clear how much these and other ACA policies will do to drive costs down. Americans pay much more for their health care than do residents of other countries in large part because prices are much higher in the United States. A CT scan costs about \$100 in Canada and \$900 in the United States.⁹⁰ Other countries keep prices lower through government-led negotiations that establish uniform reimbursement rules on an annual basis.⁹¹

THE PREDICTABLE INSTABILITY OF ACA

ACA's instability is regrettable, but not surprising. Ten years ago, as Americans were fully engaged in the health care reform debate, I identified three characteristics of stable, well-supported benefit programs in the United States that are largely lacking in ACA.⁹²

1. Americans like their benefit programs to be seen as “deserved.”⁹³ Recall in this regard that pre-ACA Medicaid was reserved for poor children or poor adults who also were disabled, pregnant, or caring for children. These categories of the poor were deserving in the sense that they could not be blamed for their inability to afford health care coverage. Medicare also serves beneficiaries who cannot be blamed for needing assistance with health care coverage. Because of their age, seniors are more likely to need expensive health care, and at the same time, they cannot be expected to be working. Medicare is seen as being deserved also because like Social Security, it is funded (in part) by payroll deductions. Medicare and Social Security are deserved because they are earned.

ACA's Medicaid expansion seemed to reflect a reconception of the “deserving poor” to include all poor persons, at least with respect to

89. Orszag & Emanuel, *supra* note 57, at 602-03.

90. Irene Papanicolas, Liana R. Woskie, & Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JAMA 1024, 1036 (2018).

91. Jonathan Oberlander & Joseph White, *Systemwide Cost Control—The Missing Link in Health Care Reform*, 361 NEW ENG. J. MED. 1131, 1132 (2009).

92. David Orentlicher, *Health Care Reform: Beyond Ideology*, 301 JAMA 1816, 1817 (2009).

93. I am describing what seems to be a common view. It is not a view that I share.

health care. But the unwillingness of many states to adopt the expansion, and the adoption of work requirements by some expansion states, suggests a lack of consensus on who among the poor count as deserving of assistance. Indeed, as I have written, the passage of ACA may have been motivated more by concerns about the high cost of health care for the non-poor than by concerns about the poor.⁹⁴

2. Federally operated programs generally are more effective than federal-state partnerships. States and the federal government share responsibility for Medicaid, and that means considerable variation in funding from state to state. Thus, Medicaid does a much better job providing access to care in Illinois than in Texas. Medicare and Social Security, on the other hand, are federally operated programs that serve people in all states well.

ACA took some important steps to make government health care more of a federal program than a federal-state partnership. For example, the federal government pays all of the subsidies for those who earn too much to qualify for Medicaid but not enough to afford health care coverage on their own.⁹⁵ In addition, the federal government pays ninety percent of the costs of the Medicaid expansion and sets uniform eligibility criteria for the expansion.⁹⁶ But Medicaid remains a federal-state partnership, and that has slowed pick-up of the expansion.

3. Programs that serve both upper- and lower-income recipients are more successful than those that only serve lower-income families. Altruism has its limits, so there is more political support for broad-based programs such as Medicare and Social Security than for programs such as Medicaid, which is paid for by higher-income families on behalf of lower-income families. The poor fare best when their fate is tied to the fate of the well-to-do.

ACA's subsidies for the purchase of health insurance have a broader base than does Medicaid. One can earn up to 400 percent of the federal poverty level and still receive subsidies but only up to 138

94. Orentlicher, *supra* note 6, at 187, 191.

95. Rachel Garfield & Kendal Orgera, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, HENRY J. KAISER FAM. FOUND. (Jun 12, 2018), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

96. Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?* HENRY J. KAISER FAM. FOUND. (May 20, 2015) <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>.

percent of the federal poverty level to qualify for the Medicaid expansion. So we can expect greater efforts to erode the Medicaid expansion than to erode the subsidies. Indeed, that already is the case. As discussed, many states have declined the opportunity to participate in the expansion, and some states are adding work requirements for expansion beneficiaries. In addition, a future Congress could reduce the federal share of the costs of the Medicaid expansion from the current ninety percent share.

The inherent instability of ACA suggests that rather than refining it, we should replace it with a program that would be stable and that actually could achieve universal coverage. Many Americans would like to see a “Medicare-for-All” kind of health care system under which people would qualify at birth for the program rather than at age sixty-five. By modeling it on the current Medicare program—universal participation, federally operated, and funded by payroll deductions—a Medicare-for-All program would include the key components of successful benefit programs.

Medicare-for-All may have strong support on the political left, but not so much on the political right. To bridge the gap, we could consider a more market-oriented alternative that also could achieve universal coverage—“Medicare Advantage-for-All.” Medicare Advantage is the private health care plan option in Medicare (Part C) under which Medicare recipients can have the government pay their premiums for a private health insurance policy.⁹⁷ In other words, Medicare Advantage is essentially a voucher program for health care, similar to the health care reform proposal promoted by Senator John McCain during his campaign for the presidency in 2008.

Voucher programs are popular with conservatives for education. Why not for health care as well? To date, health voucher proposals such as McCain’s have promised only partial payment for health care coverage rather than full coverage for a basic health care plan.⁹⁸ While a Medicare Advantage-for-All system has great promise, it also would require a substantial tax increase, making it challenging to achieve politically. Not that it would require that much of an increase in health care spending, but hundreds of billions of dollars currently spent out of private funds for health insurance would have to be converted to public funds. The popularity of vouchers runs up against the unpopularity of tax increases.

97. Orentlicher, *supra* note 3, at 346-47.

98. *Id.* at 346 n.12.

2018]

WHAT HAS BEEN ACCOMPLISHED?

413

CONCLUSION

While ACA's ultimate legacy is uncertain, its impact has been mixed. It clearly was a big step forward in terms of providing access to health care and relief from financial strain for lower- and middle-income Americans, but its impact on cost containment or the health of Americans is not as clear. In addition, its stability is subject to shifts in political control of the government. We should not expect a sustained and universal expansion of access to care absent a health care system that provides health care coverage in the same way to all Americans.