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# The Vulnerabilities of the Patient Protection and Affordable Care Act and the Tragedy of Repeal

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### THE VULNERABILITIES OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE TRAGEDY OF REPEAL

Susan A. Channick<sup>1</sup>

The Patient Protection and Affordable Care Act, (the “ACA”)<sup>2</sup> passed by Congress on March 23 2010, and signed into law by President Barack Obama on March 30, 2010,<sup>3</sup> is the first major health reform legislation to be enacted since 1965 when President Lyndon Johnson signed both Medicare and Medicaid into law. Although widely acknowledged as imperfect, the ACA is the first gateway to universal health insurance to survive the increasingly difficult legislative process. Although the vast majority of its provisions have not yet taken effect, the vulnerability of the Affordable Care Act to legislative repeal is exemplary of how the extraordinary political partisanship that permeates the American legislative process can play out. While health reform itself certainly did not cause the recent November 2, 2010 electoral “drubbing,” leadership in the House of Representatives<sup>4</sup> will change as a result from Democrat to Republican and have a similarly significant effect in the U.S. Senate<sup>5</sup> and state houses<sup>6</sup> as well. Defeating “Obamacare,” which is and has been the rallying cry of many Republicans, has moved from an administrative irritation to a real concern.<sup>7</sup>

<sup>1</sup> B.A., Cornell University; J.D. California Western School of Law; M.P.H. Harvard University

<sup>2</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>3</sup> Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 23, 2010, available at <http://www.nytimes.com/2010/03/24/health/policy/24health.html>.

<sup>4</sup> The Republicans currently have 242 seats in the House of Representative, a net gain of 63 seats. Democrats have 193 seats, a net loss of 62 seats. *112<sup>th</sup> United States Congress*, WIKIPEDIA THE FREE ENCYCLOPEDIA, [http://en.wikipedia.org/wiki/112th\\_United\\_States\\_Congress](http://en.wikipedia.org/wiki/112th_United_States_Congress).

<sup>5</sup> Democrats still hold the majority in the Senate, 51-47 with two independents caucusing with the Democrats, although they are well short of the 60-vote filibuster-proof majority that the party held after the 2008 elections. *Id.*

<sup>6</sup> After the 2010 mid-term elections, 29 governors are Republicans, 20 are Democrats, and one, Lincoln Chaffee is an independent. *2010 Gubernatorial Election Results*, NATIONAL GOVERNORS ASSOCIATION, available at <http://www.nga.org/portal/site/nga/menuitem.5cd31a89efe1f1e122d81fa6501010a0/?vgnnextoid=1ee04ec0abafb210VgnVCM1000005e00100aRCRD>.

<sup>7</sup> In March, 2010, minutes after President Obama signed the ACA into law, the Florida Attorney General Bill McCollum (R) filed suit in federal court challenging the constitutionality of the federal health reform law. Gary Fineout, *Scholars Doubt McCollum's Challenge Will Fly*, DAILY BUS. REVIEW, Mar. 25, 2010, <http://www.dailybusinessreview.com/PubArticleDBR.jsp?id=1202466964533&hbxlogin=1>. This suit has been joined by 19 other states attorneys' general. Since the filing, a number of state governors, legislators, and interest groups have

The increasingly real possibility of repeal of all or part of health care reform, while a legislative victory for its opposition, will be a tragedy for the more than 32 million currently uninsured Americans who are the beneficiaries of the ACA. As Jane Bryant Quinn has noted, “There’s something appalling about watching people with secure health insurance – members of Congress, workers with company group plans and seniors on tax-payer subsidized Medicare – trying to block access for families who are uninsured.”<sup>8</sup> In a recent Kaiser Health Tracking Poll on the influence of health care reform on the outcome of the midterm elections, eight out of ten Republicans polled reported an unfavorable view of health care reform while more than three-quarters of Democratic voters reported a favorable view of the law.<sup>9</sup> Among those with an unfavorable view of the law, nearly half say their negative opinion is driven mainly by the specifics of what the health reform law does while one third say it is more about what the health reform law says about the general direction of Washington.<sup>10</sup>

With respect to what should happen next to health care reform, 84% of Republicans want to see the law repealed entirely or in part while two-thirds of Democratic voters want to see it expanded or left as is.<sup>11</sup> While these numbers are hardly surprising considering that health care reform passed both the House and the Senate without a single Republican vote, there are provisions in the ACA that a significant number of Americans are quite satisfied with. The provisions that garnered the most support among both Democratic and Republican voters are tax credits to small businesses that offer coverage to their employees, closing the Medicare prescription drug “doughnut hole” or coverage gap for seniors, and the law’s prohibition of an insurer’s right to deny coverage to people because of their medical history or pre-existing conditions.<sup>12</sup> On the other hand, 68% of those Americans of either party who were polled favored the repeal of the so-called individual mandate which requires most Americans to have health insurance or, alternatively, pay a fine.<sup>13</sup> It is the individual mandate that is the main thrust of the multistate lawsuit currently challenging its constitutionality.<sup>14</sup>

Again, the sentiment reflected by the voting in the Kaiser poll is hardly surprising. It is, of course, the provisions that change the status quo in ways that are perceived as positive that will be the most popular and, therefore, the most secure. In a system where employment has been the

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submitted requests to join the suit and file amicus briefs. Meghan McCarthy, *Interested Parties Await Judge’s Ruling on Amicus Briefs*, NAT’L JOURNAL DAILY, Nov. 12, 2010, <http://www2.nationaljournal.com/member/daily/interested-parties-await-judge-s-ruling-on-amicus-briefs-20101112>.

<sup>8</sup> Jane Bryant Quinn, *The Elections and Health Care Reform: The Uninsured Could Lose Big Time*, MONEYWATCH, Oct. 29, 2010, <http://moneywatch.bnet.com/investing/blog/make-money/the-elections-and-health-care-reform-the-uninsured-could-lose-big-time/601/>.

<sup>9</sup> KAISER FAMILY FOUNDATION, KAISER HEALTH TRACKING POLL (Nov. 2010), *available at* <http://www.kff.org/kaiserpolls/8120.cfm>.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> United States District Court Judge Roger Vinson (N.D. Fla.) in whose courtroom the challenge to the constitutionality of the health reform law is being heard, previously rejected the government’s motion to dismiss the case and permitted the case to continue on claims that the law’s insurance coverage mandate is unconstitutional as well as state federalism claims. Vinson’s ruling said the Constitution’s commerce clause, used by Congress to justify the mandate, “had never been used to regulate inactivity – in other words, the choice not to buy health insurance.” McCarthy, *supra* note 7.

primary gateway to private health insurance,<sup>15</sup> barriers to small businesses providing health insurance have made it difficult or impossible for the employees of small businesses to obtain affordable insurance.<sup>16</sup> Since the employment gateway continues to be the key to health insurance reform, the tax credit provisions in the new law that facilitate insurance for employees of small businesses are a fix that small businesses and their employees have long been seeking.<sup>17</sup> As previously discussed, other provisions of health reform that improve accessibility and protect consumers are viewed positively by the majority of constituencies and therefore are not vulnerable to threats of partial or total repeal of the legislation. It is the provisions and consequences of the legislation that are viewed primarily as burdensome to individuals and the states that are most vulnerable to attack. Two of the most vulnerable – the individual mandate and the continued likelihood of rising health care costs – are inextricably intertwined.<sup>18</sup>

The individual mandate is the keystone of the ACA and is currently the subject of two federal lawsuits, *Florida v. United States Dep't of Health and Human Services*<sup>19</sup> and *Virginia v. Sebelius*.<sup>20</sup> The mandate requires that almost all American citizens and legal residents have qualifying health insurance or, alternatively, be subject to an annual penalty, which when fully phased-in in 2016, will be \$675 per individual and no more than three times that amount per family up to 2.5% of household income.<sup>21</sup> Although the individual mandate may seem punitive and is being challenged as exceeding the powers of the federal government to regulate the conduct of its citizens and legal residents, its inclusion in the new legislation is a fundamental prerequisite to the success of health care reform.

One of the acknowledged reasons for the failure of the current health insurance system is its voluntariness.<sup>22</sup> All insurance works most effectively when risk is widely spread among the largest

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<sup>15</sup> Currently approximately 59% of Americans under the age of 65 have access to health insurance through their employment; that percentage is projected to remain relatively static through 2019 when health care reform reaches the one decade mark. ELISE GOULD, ECONOMIC POLICY INSTITUTE, DECLINE IN EMPLOYER-SPONSORED HEALTH COVERAGE ACCELERATED THREE TIMES AS FAST IN 2009 (Sep. 16, 2010), available at [http://www.epi.org/publications/entry/decline\\_in\\_employer-sponsored\\_health\\_coverage\\_accelerated](http://www.epi.org/publications/entry/decline_in_employer-sponsored_health_coverage_accelerated).

<sup>16</sup> Under the current health insurance regime, individuals and small businesses have suffered in the insurance marketplace because of lack of large risk pools due to their small numbers. Insurers have insisted on experience or actuarial ratings in these marketplaces in order to ensure sufficiently high premiums to cover the cost of the sick making health insurance substantially more expensive for both small employers and their employees. Many small employers either do not offer health insurance shift the cost of the insurance to the employee. Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993).

<sup>17</sup> Ironically, although tax credits for small businesses that provide health insurance to their employees get good marks, premium credits and cost-sharing subsidies to lower-income individuals who do not get their health insurance through their employer received much lower marks among Republicans who were polled. KAISER FAMILY FOUNDATION, *supra* note 9.

<sup>18</sup> Currently, the United States spends \$2.5 trillion or 17.3% of GDP on health care. The prediction is that if the status quo continues, by 2019, health care will cost \$4.5 trillion and consume of 19.3% of GDP. Christopher J. Truffer et. al., *Health Spending Projections Through 2019: The Recession's Impact Continues*, 29 HEALTH AFFAIRS 522 (2010).

<sup>19</sup> *Florida v. U.S. Dep't of Health and Human Services*, No. 3:10-cv-91-RV/EMT (N.D. Fla., Mar. 23, 2010).

<sup>20</sup> *Virginia v. Sebelius*, 702 F. Supp. 2d 598, 605-606 (E.D. Vir. 2010).

<sup>21</sup> The penalty is subject to a ceiling of 3 fines of \$675 per family or 2.5% of household income and will be phased in over a three-year period starting in 2014 and ending with full phase-in in 2016. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1501 (2010). The exemptions provided are ones for financial hardship, religious objections, American Indians, and incarcerated individuals. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 10106 (2010).

<sup>22</sup> Ezra Klein, *How Does the Individual Mandate Work?*, WASH. POST, Mar. 25 2010, [http://voices.washingtonpost.com/ezra-klein/2010/03/how\\_does\\_the\\_individual\\_mandat.html](http://voices.washingtonpost.com/ezra-klein/2010/03/how_does_the_individual_mandat.html).

possible pool of those at risk of the occurrence of a hazardous event. Universal health insurance systems, particularly single-payer systems, in other countries and Medicare in the United States work on the principle that health insurance is most cost-effective if the entire population comprises a single pool. All members of the pool pay premiums that are unrelated to their consumption of health care or health status though it may be related to their wealth status.<sup>23</sup> In such large unfragmented pools, the costs of care of the relatively small percentage of the pool whom are sick or injured will be cross-subsidized by the insurance premiums of the healthy members who comprise the majority of the pool.<sup>24</sup> The statistics of the distribution of health care costs in the population make it clear that in order to be cost-effective, the healthy, who consume a small fraction of health care resources, must participate in the insurance pool in order to counteract the costs of care of those who are unfortunate enough to be unhealthy and therefore require a disproportionately larger share of the health care resources. This regime does not work if the purchase of health insurance is voluntary and otherwise healthy individuals either do not purchase insurance at all or purchase it only when they are diagnosed with an illness or require an expensive medical procedure.

In a health insurance system that is not, by design or incentive, universal, the role of the individual mandate is to ensure the presence of the healthy as well as the unhealthy in the insurance pool. Without the mandate, people who are young and healthy will often elect not to purchase health insurance. From the economic perspective that individual preferences should guide demand, this decision makes sense.<sup>25</sup> People who opt out of health insurance pools do so because they believe the risk of ill health is minimal or negligible and are willing to take the risk of the burden of unexpected ill health in exchange for no health insurance premium payments. As previously stated, this is a completely rational choice which is further legitimized by the availability of high deductible catastrophic insurance often coupled with a tax-advantaged health savings account.<sup>26</sup> The availability of high deductible catastrophic insurance tends to appeal to people who are relatively healthy and the existence of health savings accounts to cover the underlying high deductible is appealing to the relatively wealthy since there are tax benefits that accrue to contributions to health savings accounts.<sup>27</sup>

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<sup>23</sup> This is the concept of social insurance that views ill health as a future risk that everyone in the population has but that few actually will suffer. To a large extent, sickness is a matter of random bad luck and the solidarity approach of social insurance ensures that the fortuity of sickness does not financially over-burden the sick person but is shared with everyone. Stone, *supra* note 16.

<sup>24</sup> One of the aberrations of health care costs is that they are highly skewed in the population. The top five percent of health care users account for more than fifty percent of health care costs while the bottom fifty percent of users account for only three percent of health care costs. Linda J. Blumberg & John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 NEW ENG. J. MED.6 (2009).

<sup>25</sup> Mark V. Pauly, *Public Health Care and Health Insurance Reform – Varied Preferences, Varied Options*, 360 NEW ENG. J. MED. 2271, 2271 (2009).

<sup>26</sup> Health Savings Accounts (also known as Medical Savings Accounts) are part of a consumer-directed health care movement in which advocates believe that, if health care were in the hands and control of individuals, people would be substantially more aware of the costs of health care and would be much more knowledgeable purchasers of health care goods and services. Since at least some percentage of health care costs are alleged to be unnecessary, the argument continues that consumers conscious of the necessity (and cost) of what they are purchasing would be much more careful and thrifty consumers. Elizabeth Boehm, *The Myth of Consumer-Directed HealthCare*, HARVARD BUS. REVIEW, Apr. 27, 2010, [http://blogs.hbr.org/cs/2010/04/the\\_myth\\_of\\_consumer-directed.html](http://blogs.hbr.org/cs/2010/04/the_myth_of_consumer-directed.html).

<sup>27</sup> Health savings accounts are constructed similarly to Individual Retirement Accounts and flexible benefit accounts. Contributions made by the individual are from pre-tax income and any amount unspent at the end of the contribution period can remain in the account to be used in successive tax years. HSAEducator.com, HSA Rules for Employers, <http://www.hsaeducator.com/hsa-rules/>.

As healthier and wealthier people opt out of insurance risk pools, these pools become concentrated with a higher percentage of unhealthy participants; the diluting effect of the healthy in the risk pool is gone. The result of this so-called adverse selection is that a larger percentage of the remaining pool will require health care because it is in the economic interests of the unhealthy and less wealthy to select into the health insurance risk pool rather than opt out.<sup>28</sup> As health care costs inevitably rise for the participants in the risk pool, insurers who are not prohibited from so doing will experience rate the members of the pool resulting in higher health insurance premium costs to cover the higher projected costs of health care.<sup>29</sup> This rise in health insurance premium costs will undoubtedly affect the choice of the healthier remaining members of the pool who may now opt out rather than pay the higher cost of the premiums. This leaves the pool with an even higher concentration of people who are unhealthy and therefore are greatly incentivized to stay in the pool. As this cycle continues, premiums become unaffordable for even unhealthier members of the pool who may have no choice but to opt out and become part of the large number of uninsured Americans currently estimated to be at least 50 million.<sup>30</sup> This cycle is known as the adverse selection death spiral, an insurance phenomenon which plagues health insurance in the United States in populations where there is no mandatory requirement or sufficient incentive to bring everyone who is eligible into the risk pools.<sup>31</sup>

Although there are cogent arguments to be made that the ACA does not do enough to avoid the fragmentation of risk pools that will still exist after implementation of health care reform,<sup>32</sup> repeal of the individual mandate renders the ACA completely untenable and health reform economically unsustainable. The ACA, when fully implemented, is predicted to bring another 32 million American citizens and legal residents into regulated insurance pools.<sup>33</sup> The expense of covering an additional 32 million people is clearly going to be significant but one of the underlying assumptions of health care reform is that this added expense could be at least partially offset by

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<sup>28</sup> Adverse selection is the separation of healthier and less-healthy people into different health insurance arrangements. Unhealthy people tend to select into the health insurance risk pool because the probability of their requiring health care is greater than the probability for a healthier population. The less wealthy may also opt into the risk pool if the deductible is more than they think they can afford out of pocket. See Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J. L. & MED. 7 (2010).

<sup>29</sup> Health insurers would ideally like to be able to experience or actuarially rate all insureds in order to protect themselves from health care costs in excess of revenues. Stone, *supra* note 16. States, which have had the authority to regulate insurance companies, often require that insurers use community rather or modified community rating. Under the ACA, the legislation also requires a modified form of community rating allowing insurers to vary their premiums only with regard to age, premium rating area, family composition and tobacco use. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 2701 (2010).

<sup>30</sup> Susan A. Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 LAW & INEQ. 1 (2010).

<sup>31</sup> Jonathan Cohn, *Sticker Shock*, THE NEW REPUBLIC, Feb. 9, 2010, <http://www.tnr.com/blog/the-treatment/sticker-shock>.

<sup>32</sup> First, the penalty for failing to obtain health insurance is relatively nominal so that health individuals may opt to pay the \$675 rather than what will predictably be much more expensive health insurance premiums. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1501 (2010). Second, states that allow insurers to sell health insurance outside the exchanges more inexpensively than inside could create incentives for healthier individuals and small businesses to opt out of the health insurance exchanges thereby reducing both the size and the relative health of the pools driving the premiums inside the exchanges higher in an adverse selection spiral. Hoffman, *supra* note 28.

<sup>33</sup> Peter Swanson, *Emergency Medical Services: How Health Reform Could Hurt First Responders*, National Center for Policy Analysis (Brief Analysis No. 737) (Jan. 11, 2010), available at <http://www.ncpa.org/pdfs/ba737.pdf>.

lower insurance premiums because of reduced fragmentation of risk pools.<sup>34</sup> However, if the individual mandate is repealed, the beneficial economic effects of risk-pooling will be lost and the United States will be in the position of having passed health care reform that must be financed through deficit spending, something President Obama promised would not occur.<sup>35</sup> One of the strange ironies of health care reform is that its most essential provision – the individual mandate – is its most unpopular provision and therefore highly susceptible to attack and possible repeal.<sup>36</sup>

It is also ironic as well as not widely understood that some of the more popular and generally acceptable provisions of health care reform were able to be included only because of the inclusion of the individual mandate.<sup>37</sup> The provisions of the ACA that regulate health insurance are possible only if everyone is required to have health insurance. The provision of the ACA that makes it illegal to deny insurance to people who are ill or have preexisting conditions that are predictive of ill health is possible only because everyone – sick or well – is required to purchase health insurance. Health insurers surely would not have agreed to support legislation that encouraged adverse selection without the concomitant right of insurers to refuse to cover individuals who currently are or are likely to be sick and therefore expensive to care for. While it makes little sense to incentivize insurance companies to prefer profit to the good health of their insureds, it is imperative in a privatized health care system that the players such as the insurers need to be profitable in order to survive and continue to provide insurance. Risk fragmentation that creates unhealthier risk pools makes it difficult for insurers to be profitable without denying coverage to people who are sick or who are likely to become sick.

So how will supporters of health care reform educate the public that the individual mandate is the keystone of sustainable health care reform? At a meta-level, this is difficult because of the general preference of many, perhaps the majority, of Americans for less interference by government in their lives.<sup>38</sup> Any government program which proposes to require Americans to do something about which they currently have a choice is viewed as an intrusion of individual freedoms and

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<sup>34</sup> The cost of health care reform in the first decade (2009-2019) is estimated to be around \$1 trillion much of which will be the cost of insuring Americans who are currently un- or under-insured; Jennifer Haberkorn, *CBO ups health care cost projections*, POLITICO, May 12, 2010, <http://www.politico.com/news/stories/0510/37081.html>.

<sup>35</sup> Enacting new legislation and finding sources of revenue to pay for it are clearly not the same things. Douglas Holtz-Eakin & Michael J. Ramlet, *Health Care Reform Is Likely To Widen Budget Deficits, Not Reduce Them*, 29 HEALTH AFFAIRS 1136 (2010). President Obama will be confronted with a similar situation before the end of the year when Congress will be required to make a decision about the expiring Bush-era tax cuts for high-income individuals and couples. Only 40 percent of those in the November 2, 2010 exit poll approved of an extension of all Bush tax cuts. Extending the tax cuts to the wealthiest individuals would add \$700 billion to the federal deficit. Frank Rich, *Who Will Stand Up To The Superrich?*, N.Y. TIMES (Nov. 13, 2010), available at <http://www.nytimes.com/2010/11/14/opinion/14rich.html>. The new appointed National Commission on Fiscal Responsibility and Reform, established by the President by executive order on February 18, 2010, has identified health care costs, particularly in government programs, as one of the major drivers of the growing federal budget deficit and as a target for cost containment policies. The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth* (Dec. 2010), available at [http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12\\_1\\_2010.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf).

<sup>36</sup> Although the individual mandate may be the most vilified provision of the ACA, it is unlikely to be repealed in the next two years of President Obama's term. First, Republicans do not have a majority much less a filibuster-proof majority in the Senate. Second, President Obama is certain to veto any attempt at repeal of health care reform. Jonathan Oberlander, *Beyond Repeal – The Future of Health Care Reform*, 363 NEW ENG. J. MED. 2277 (Dec. 9, 2010).

<sup>37</sup> Linda J. Blumberg and John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 N. Engl. J. Med. 1 (2009).

<sup>38</sup> Paul Krugman, *This recession is Reagan's legacy*, JOURNAL NEWS, June 2, 2009, <http://www.journal-news.com/opinion/columnists/paul-krugman-this-recession-is-reagans-legacy-142418.html>.

personal liberties; witness the recent wave of libertarianism symbolized by the Tea Party and other very conservative political groups. Also likely to influence individual voters against the validity and value of federal health reform are the recent lawsuits brought by a number of states attorneys general against the federal government alleging the unconstitutionality of the individual mandate and, in some of the cases, challenging other provisions of the ACA such as the expansion of the state Medicaid programs.<sup>39</sup>

Federal District Court Judge Henry Hudson, who presides over the case in Virginia's Eastern District, recently rejected the government's standing argument finding harm to Virginia because of the conflict between the ACA and Virginia's own law passed specifically to create standing to sue for Virginia.<sup>40</sup> On December 13, 2010, Judge Hudson, on a motion for summary judgment, upheld Virginia's constitutional challenge to section 1501 of the ACA.<sup>41</sup>

Notwithstanding that fourteen federal judges have already dismissed cases challenging the law with two explicitly upholding the constitutionality of the individual mandate, Judge Hudson agreed entirely with the Commonwealth holding that Congress can only regulate "economic activity" in cases where the subject has voluntarily entered the stream of commerce.<sup>42</sup> Since the federal legislation seeks to compel individuals to enter the stream of commerce by purchasing a commodity in the private market, the provision is beyond the reach of the Commerce Clause powers.<sup>43</sup> This complex constitutional analysis is likely to be beyond the understanding of the vast majority of Americans who are insufficiently knowledgeable about state and federal legal procedures to understand and evaluate the conflict. With little other guidance, they will undoubtedly be influenced by the opening of secondary sources; many of whom also lack sufficient knowledge as well as the will to educate. So, even if a preponderance of federal judges find the law constitutional, Americans, through the media, are likely to be unduly influenced by the few who do not.

At a micro-level, public education is similarly difficult. Understanding the Patient Protection and Affordable Care Act, a very complex piece of legislation, is a daunting task even for individuals who are inclined to thoughtful examination and evaluation of its provisions. Even those striving to be good and informed citizens have an uphill battle when it comes to understanding the complex legislation and possible constitutional challenges. Among this population, there are many who remain doubtful of the value of health reform because a Democratic administration and Democratic Congress never successfully sold it to the public during the legislative process. The ACA is intended to be insurance reform leading to universal coverage but it does not make everyone's health insurance coverage better or less expensive, certainly not immediately. In order to provide coverage for people who cannot afford health insurance and are not eligible for public health insurance

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<sup>39</sup> Travis Pillow, *Can Medicaid Funding be Coercive*, THE FLORIDA INDEPENDENT, Jan. 14, 2011, <http://floridaindependent.com/19213/can-medicaid-funding-be-coercive>.

<sup>40</sup> The Virginia law at issue in the case, the Virginia Health Care Freedom Act, is based on a model act drafted by the American Legislative Exchange Council, a group in Washington, D.C. that advocates limited government and free markets. Federal district court judge Henry Hudson stated in his memorandum on the government's motion to dismiss Virginia's constitutional challenge, that "[D]espite its declaratory nature, it is a lawfully-enacted part of the laws of Virginia. The purported transparent legislative intent underlying its enactment is irrelevant. The mere existence of the lawfully-enacted statute is sufficient to trigger the duty of the Attorney General of Virginia to defend the law and the associated sovereign power to enact it." *Virginia v. Sebelius*, 702 F. Supp. 2d 598, 605-606 (E.D. Vir. 2010).

<sup>41</sup> *Virginia v. Sebelius*, 702 F. Supp. 2d 598, 605-606 (E.D. Vir. 2010).

<sup>42</sup> *Id.* at 611-12.

<sup>43</sup> *Id.* at 612.



programs such as Medicaid, the government will provide federal subsidies which must have a corresponding revenue source.<sup>44</sup> The revenue sources tend to disproportionately burden the wealthy who will be paying for the expansion of health care access through additional taxes but not directly benefiting from the additional tax burden.<sup>45</sup> In a country like the United States of America, where social solidarity is anathema to many, explicit cross-subsidization often does not sit well.<sup>46</sup>

Much has been written regarding the difficulty of repealing legislation that is providing benefits to many. And the ACA has many benefits to confer on Americans who have been literally paralyzed with fear of losing their employer-sponsored health insurance and being left to the vicissitudes of the individual health insurance market.<sup>47</sup> So the federal insurance reform provisions in the ACA that prevent denials of coverage, rescissions of insurance when the insured becomes ill, yearly and lifetime caps on the amount of insurance coverage, and provide coverage for adult children on their parents' insurance until the age of 26, are welcome changes to a heretofore unfriendly status quo. Unfortunately, most of these provisions do not take effect immediately and many, such as guarantee issue and renewability of health insurance, do not become effective until 2014.<sup>48</sup> Although Democrats had many reasons for delaying the implementation of the insurance reforms until 2014, the legislation is now at greater risk of attack because most Americans have not yet benefited from health care reform and therefore are less invested in its sustainability.<sup>49</sup>

While the individual mandate is the focus of immediate attack on the ACA, the longer term and less partisan problem is cost. We are currently living in times of extraordinary deficit spending with a projected deficit for fiscal year 2010 alone in excess of \$1.3 trillion<sup>50</sup> and a total deficit

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<sup>44</sup> BOWEN GARRETT ET. AL., URBAN INSTITUTE, TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES, PREMIUM AND COST-SHARING SUBSIDIES UNDER HEALTH REFORM: IMPLICATIONS FOR COVERAGE, COSTS, AND AFFORDABILITY (2009), available at [http://www.urban.org/uploadedpdf/411992\\_health\\_reform.pdf](http://www.urban.org/uploadedpdf/411992_health_reform.pdf).

<sup>45</sup> High income earners are particularly vulnerable to additional taxes for Medicare and surtaxes on so-called "Cadillac" health insurance policies. Employers who have never been mandated to provide health insurance will be subject to a pay-or-play penalty. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

<sup>46</sup> See generally, Channick, *supra* note 30.

<sup>47</sup> It is the individual and small business health insurance markets where adverse selection has wrecked havoc with consumers' ability to obtain insurance for reasonable costs. Because a disproportionate number of people in the individual markets have medical conditions for which they require health insurance, Insurers have used actuarial ratings to price insurance. They have also used tools such as refusal to issue insurance or rescission of insurance to people who are ill to control the amounts that they must pay out for health care.

In early 2010, Anthem Blue Cross, a wholly-owned subsidiary of Wellpoint, tried to raise premiums on individual policies by as much as 39%. After review by state insurance regulators, Anthem will raise rates on individual policies averaging 14% and as high as 20% Duke Helfand, *Anthem cleared to hike rates; State regulators say they aren't blessing increases of up to 20% but can't stop them*, L.A. TIMES, Aug. 26, 2010, at B1.

<sup>48</sup> Implementation Source, *Health Reform Timeline*, KFF.org, <http://healthreform.kff.org/timeline.aspx>.

<sup>49</sup> The decision to delay the implementation of the ACA's health insurance reforms until 2014 was prompted by the projected difficulties in designing the health insurance exchanges, a linchpin of the ACA. The delay was also prompted by the perceived need to keep the cost of reform in the first decade under \$1 trillion, a goal that could be accomplished by delaying insurance reforms, the costliest part of reform. Harold Pollack, *The Cost of Delayed Reform*, THE AMERICAN PROSPECT, Aug. 27, 2010, [http://www.prospect.org/cs/articles?article=the\\_cost\\_of\\_delayed\\_reform](http://www.prospect.org/cs/articles?article=the_cost_of_delayed_reform).

<sup>50</sup> The CBO expects federal revenues to total \$2.1 trillion while outlays are expected to total \$3.5 trillion, a short-fall of approximately \$1.3 trillion. While revenue is projected to climb sharply in the next few years, most of the additional revenue is attributable to the scheduled expiration of tax provisions and anticipated economic recovery. See CONGRESSIONAL BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: AN UPDATE (Aug. 2010), available at <http://www.cbo.gov/ftpdocs/108xx/doc10871/08-18-Update.pdf>.

projection for 2010 of approximately \$14 trillion.<sup>51</sup> Spending on health care alone in 2009 was \$2.5 trillion or 17.3% of GDP which, at the current rate of growth, is predicted to be \$4.5 trillion or 19.3% of GDP by 2019.<sup>52</sup> While the Congressional Budget Office initially predicted that the ACA would have a net positive budget effect of \$143 billion in the first decade following its passage<sup>53</sup> as a result of a combination of reforms such as the individual mandate, the health insurance exchanges and/or the federal subsidies, whether this prediction will be accurate is, at the least, unclear.<sup>54</sup> In any case, the reasons for the high cost of health care in the United States exist today regardless of the success or failure of health care reform. And, whether or not health care reform withstands future attacks, there is general agreement that the rising costs of health care are unsustainable.<sup>55</sup> Medicare and other federal health insurance programs alone are projected to rise from five percent of GDP in 2010 to 10% of GDP in 2035.<sup>56</sup> This inexorable rise in health care costs will likely have the effect of slowing economic growth and crippling the economy with ever-rising federal debt which must continue to be serviced.<sup>57</sup>

In addition to the real economic effects of the ever-growing fiscal burden of health care, its perceived relationship to this fiscal burden makes the ACA a convenient target and increases its vulnerability to attack and possible repeal. While it is certainly true that health care costs would continue to rise regardless of the passage of health care reform, the general unpopularity of the ACA as well as the current administration makes the ACA a convenient target of legitimate budgetary concerns as well as more spurious partisan politics. Certainly a new and mostly unimplemented piece of legislation like the ACA is more likely to be caught in the cross-fire of initiatives seeking to reduce the deficit than venerable and entrenched entitlement programs such as Medicare and Social Security that are relied on by large segments of the population.<sup>58</sup>

“Bending the cost curve,” as the saying goes, among health policy experts and health economists, must be a part of any attempt to reform health care in the United States. Indeed, there are a number of policy experts and health economists who believe it was foolhardy for the Obama administration to use so much of its political capital to pass health care reform legislation that does not mandate initiatives for bending the cost curve as well as ensuring high quality care.<sup>59</sup> President Obama, having the failures of the Carter and Clinton administrations as templates, decided to tackle some reforms – insurance – and not others – cost. Insurance reforms required concessions from the insurers that could be satisfied with the addition of another 32 million individuals to their

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<sup>51</sup> The CBO’s projection of total deficit in 2020 is almost \$7 trillion, one-half of the 2010 deficit due, in large part, to an increase in revenues. *Id.* at 3, Summary Table 1.

<sup>52</sup> Truffer, *supra* note 18.

<sup>53</sup> DOUGLAS W. ELMENDORF, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, LETTER TO SPEAKER OF THE HOUSE OF REPRESENTATIVES, NANCY PELOSI (Mar. 20, 2010) (on file with author).

<sup>54</sup> Haberkorn, *supra* note 34.

<sup>55</sup> Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601 (Aug. 12, 2010).

<sup>56</sup> CONGRESSIONAL BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK, THE LONG-TERM OUTLOOK FOR MEDICARE, MEDICAID AND TOTAL HEALTH CARE SPENDING, (June 2009), available at <http://www.cbo.gov/ftpdocs/102xx/doc10297/Chapter2.5.1.shtml>.

<sup>57</sup> Henry J. Aaron and Paul Ginsburg, *Is Health Care Spending Excessive? If So, What Can We Do About It?*, 28 HEALTH AFFAIRS 1260 (September/October 2009).

<sup>58</sup> Lori Montgomery, *GOP leaders agree to panel on federal deficit*, WASH. POST (Feb. 19, 2010), available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/18/AR2010021805554.html>.

<sup>59</sup> William G Weissert & Carol S. Weissert, *Why Major Health Reform in 2009-10 Won't Solve Our Problems*, 8 THE FORUM (2010).

customer rolls. Meaningful cost control meant taking on providers, a much more daunting task.<sup>60</sup> So while the ACA contains some cost control measures, mostly in the nature of Medicare pilot projects, it is certainly not dedicated seriously to bending the health care cost curve.

The recent midterm elections have put Republicans in the driver's seat for setting the political agenda at least in the House of Representatives. Representative (and Speaker of the House) John Boehner (R – OH) has fired the first shot across the bow of health insurance reform implementation saying, "They'll get not one dime from us."<sup>61</sup> Apparently the Republicans' plan to defeat the ACA includes not only the possibility of direct repeal but also the tactic of starving the legislation by refusing to allocate to it the funding necessary for its implementation. While repeal of the ACA would be politically devastating to the Obama administration and the Democratic Party, the consequences are much more tragic for the 32 million or undoubtedly more Americans whom are poised to finally have access to affordable, decent health care. As author Jane Bryant Quinn, quoting Shakespeare to describe the moral dilemma raised by a continuation of a health care regime that rations by good health and sufficient wealth, "[i]f you prick them, do they not bleed?"<sup>62</sup> As we all know too well, tragically indeed they do.

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<sup>60</sup> The Medicare Sustainable Growth Rate (SGR) formula was enacted in the 1997 Balanced Budget Act to ensure that Medicare reimbursement did not exceed the growth in gross domestic product. The problem is that Congress has traditionally been unable and unwilling to enforce the limits on physician reimbursement so that currently, in order to reconcile physician reimbursement and GDP as required by the SGR, Medicare providers are scheduled to undergo a 23% cut in their reimbursement. Based on history, there is great doubt that Congress will be able to make these cuts and will fashion, as usual, a temporary fix that will await the next session of Congress for the possibility of a real fix. Chris Silva, *Brief Medicare fix may mean showdown in lame-duck Congress*, AM. MED. NEWS, July 19, 2010, <http://www.ama-assn.org/amednews/2010/07/19/gv110719.htm>.

<sup>61</sup> Quinn, *supra* note 8.

<sup>62</sup> *Id.*