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Recommended Citation

Orentlicher, David, "The Future of the Affordable Care Act: Protecting Economic Health More than Physical Health?" (2014). *Scholarly Works*. 1047.

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COMMENTARY

THE FUTURE OF THE AFFORDABLE CARE ACT: PROTECTING ECONOMIC HEALTH MORE THAN PHYSICAL HEALTH?

*David Orentlicher**

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I. INTRODUCTION

Mark Hall has written a terrific symposium paper.¹ It is exactly the kind of scholarship that we need to see as the Affordable Care Act (ACA) continues its roll out. We can make educated guesses about the impact of the ACA, but we will not be able to make reliable judgments until we have hard data. By measuring actual outcomes, we will be able to sort out disagreements among experts regarding the likely effects of the ACA's various provisions.

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1. Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 HOUS. L. REV. 1029 (2014).

While observers have focused on questions about the extent to which the ACA will improve access to care, reduce the costs of care, and improve the quality of care, commentary has largely ignored an even more important question—to what extent will the ACA improve health? Surprisingly, the link between health care insurance and health is more tenuous than one might think. In the end, the ACA may do more to protect the financial health of poor Americans than to improve their physical health.

II. COMMON QUESTIONS ABOUT THE IMPACT OF THE ACA

With the roll out of the health insurance exchanges in the fall of 2013, much analysis considered whether insurance premiums would increase, decline, or remain about the same in the individual market.² So far, the evidence suggests that most people will get more for their insurance premium dollar under the ACA.³ And this makes sense. When insurers were pricing their policies, they expected that the ACA's individual mandate to purchase insurance would bring more of the younger and healthier population into the insurance risk pool, allowing a greater spreading of the costs of care for older, sicker persons.⁴ In addition, the health insurance exchanges make it easier for consumers to compare their options and find the best value.

2. Editorial, *High and Low Premiums in Health Care*, N.Y. TIMES, Nov. 11, 2013, at A24; Robert Pear & Reed Abelson, *Officials Detail Premium Costs of Health Plan*, N.Y. TIMES, Sept. 25, 2013, at A1. Of course, premiums do not tell the whole story. People also have to consider “deductibles and other out-of-pocket costs.” Robert Pear, *On Health Exchanges, Premiums May Be Low, but Other Costs Can Be High*, N.Y. TIMES, Dec. 9, 2013, at A18. The individual market includes health insurance plans purchased by people for themselves or their families and is distinguished from the market for group insurance plans. Most Americans with private insurance are covered through group plans that are sponsored by their employers. KAISER COMM'N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER 1–3* (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-key-facts-about-health-insurance.pdf>.

3. See *infra* note 27 and accompanying text.

4. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2585 (2012). Early reports found that younger Americans were slower to purchase policies on the health insurance exchanges. See Haeyoun Park, *Tracking the Ages of Health Care Enrollees: Will Enough Young People Sign Up?*, N.Y. TIMES (Dec. 13, 2013), http://www.nytimes.com/interactive/2013/12/14/us/tracking-the-ages-of-health-care-enrollees.html?_r=0 (reporting that older people constitute the bulk of private plans enrollees). But that may have been a temporary phenomenon. See ASPE OFFICE OF HEALTH POLICY, DEP'T OF HEALTH & HUMAN SERVS., *HEALTH INSURANCE MARKETPLACE: JANUARY ENROLLMENT REPORT 4* (2014), available at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf (“[T]here was a more than eight-fold increase in the cumulative number of young adults . . . who have selected a Marketplace plan through the [Federally-facilitated Marketplace] during the month of December.”).

However, the ACA's impact on premiums will be uneven. The ACA's ban on premium surcharges for diabetes, heart disease, or other "preexisting medical conditions" will favor people with preexisting conditions over those without health problems,⁵ and urban dwellers generally should see lower rates than their rural counterparts.⁶ The ACA also will eliminate many low-cost options. Because the ACA requires insurance plans to meet minimum coverage standards, some people will have to switch from their pre-ACA plans to more generous, and therefore, more expensive plans.⁷

Another important question is the extent to which the ACA's individual market reforms will ease the "job lock" problem.⁸ Before the ACA's reform of the individual market, high premiums caused by preexisting conditions created a substantial obstacle to job mobility.⁹ For example, scientists in academia or industry who wanted to start their own companies would face very high health care costs if someone in their family had a history of medical problems. Those costs might deter the budding entrepreneur. Under the ACA, the creator of a start-up company will have access to a community-rated health insurance plan, with subsidies for purchasers whose income does not exceed 400% of the federal poverty level.¹⁰

Data will help us judge provisions of the ACA other than those dealing with the market for individual insurance. For example, to what extent will the ACA's employer mandate discourage hiring and increase the rate of unemployment or underemployment? The employer mandate applies to businesses with at least fifty employees,¹¹ so some businesses may slow their hiring when their number of employees gets close to fifty. In addition, for employers

5. By requiring insurers to charge healthy and unhealthy persons the same amount, the ACA essentially requires healthy persons to subsidize the costs of care for those who suffer from illness. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2585, 2613–15.

6. Reed Abelson, Katie Thomas & Jo Craven McGinty, *Health Law Fails to Lower Prices for Rural Areas*, N.Y. TIMES, Oct. 24, 2013, at A1.

7. Jonathan Weisman & Robert Pear, *Cancellation of Health Care Plans Replaces Website Problems as Prime Target*, N.Y. TIMES, Oct. 30, 2013, at A17. The federal government postponed the essential benefits requirement for the first three years of the individual mandate. Robert Pear, *Some Policies Get More Time in Health Shift*, N.Y. TIMES, Mar. 6, 2014, at A1; *What Does Marketplace Health Insurance Cover?*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-does-marketplace-health-insurance-cover/> (last visited Mar. 11, 2014) (describing essential health benefits).

8. James Surowiecki, *The Business End of Obamacare*, NEW YORKER, Oct. 14, 2013, at 42.

9. *Id.*

10. 26 U.S.C. § 36B(b)(3)(A)(i) (2012).

11. *Id.* § 4980H(c)(2)(A). More specifically, the mandate kicks in at fifty full-time equivalents. *Id.* § 4980H(c)(2)(E).

subject to the mandate, coverage must be provided only to employees who work at least thirty hours per week.¹² As a result, some employers will limit the hours worked per week for many of their employees at twenty-nine.¹³ Experts differ on the extent to which the ACA will affect hiring decisions,¹⁴ and hard data will be very important in sorting this issue out. In the meantime, data to date do not suggest a major impact.¹⁵

Good data also can tell us when our intuitions lead us astray. The real world often acts in unexpected ways. For example, it is often assumed that when the government cuts its reimbursement rates under Medicare and Medicaid, hospitals and other health care providers will respond by raising fees for privately insured patients. Indeed, McCue and Hall found that:

One national insurer . . . attributed a portion of its [2012–2013 rate] increase to concerns that the [ACA] will reduce provider payments under Medicare and Medicaid, causing providers to increase the amount they charge privately insured patients. This insurer did not state[, however,] that such cost-shifting had already happened, and recent literature questions the extent to which it tends to occur.¹⁶

McCue and Hall cite a study published in the May 2013 issue of *Health Affairs* in which the researcher found that

12. *Id.* § 4980H(c)(4)(A).

13. Of those employers who limit hours worked, some will impose the limits not so they can drop previously provided coverage but so they can avoid having to extend coverage to workers who previously were not eligible for the employer's health care plan. J.D. Harrison, *Obamacare Prompting Businesses to Cut Employee Hours? So Far, Yes and No*, WASH. POST (Oct. 29, 2013), http://www.washingtonpost.com/business/on-small-business/obamacare-prompting-businesses-to-cut-employee-hours-so-far-yes-and-no/2013/10/29/f1fee542-40b7-11e3-a624-41d661b0bb78_story.html.

14. Compare Andrew Puzder, Op-Ed., *ObamaCare and the Part-Time Economy*, WALL ST. J., Oct. 11, 2013, at A15 (suggesting that the impact of the ACA has had obvious negative effects on hiring), with Carlos Torres, *Economists See Little Effect on Hiring from U.S. Health-Care Law*, BLOOMBERG (Jan. 26, 2014), <http://www.bloomberg.com/news/2014-01-27/economists-see-little-effect-on-hiring-from-u-s-health-care-law.html> ("The vast majority of U.S. companies said the implementation of the Obama administration's health-care law will have no effect on their businesses or hiring plans . . .").

15. Ben Casselman, *Part-Time Work Still Up, but Health Law Isn't the Cause*, WALL ST. J., Oct. 23, 2013, at A4; Stephen Rattner, Op-Ed., *The Biggest Economy Killer: Our Government*, N.Y. TIMES (Oct. 23, 2013), <http://www.nytimes.com/2013/10/24/opinion/rattner-the-biggest-economy-killer-our-government.html>. But see Robert Pear, *Public Sector Capping Part-Time Hours to Skirt Health Care Law*, N.Y. TIMES, Feb. 21, 2014, at A12 (indicating that public sector employers are limiting many of their employees to no more than twenty-nine hours per week); Puzder, *supra* note 14.

16. MICHAEL J. MCCUE & MARK A. HALL, COMMONWEALTH FUND, WHAT'S BEHIND HEALTH INSURANCE RATE INCREASES? AN EXAMINATION OF WHAT INSURERS REPORTED TO THE FEDERAL GOVERNMENT IN 2012–2013, at 6 (2013), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/17_21_McCue_whats_behind_hlt_ins_rate_increases_ib.pdf.

reductions in Medicare reimbursement to hospitals for inpatient care have led to complementary reductions in inpatient payments by private insurers rather than the increases found by other researchers.¹⁷ According to the author, the decline in private payments could have occurred because private payment rates are often set as a multiple of Medicare payment rates or because cuts in Medicare reimbursement cause hospitals to lower their operating costs.¹⁸ A subsequent study suggests that the latter effect is important.¹⁹ When Medicare reduced its payments to hospitals, they appeared to respond by reducing their capacity (e.g., by decreasing their number of beds for inpatients).²⁰

Rather than cost-shifting from the government to the private sector, we may see a significant cost shift in the opposite direction. A major question about the ACA is the extent to which the expansion of governmental health care benefits will “crowd out” private health care insurance.²¹ That is, when government health care programs expand, they reach not only previously uninsured Americans but also Americans for whom it is less expensive to use the government program than to continue relying on the private sector. When Congress expanded Medicaid through the Children’s Health Insurance Program (CHIP) program, some low-income families dropped their private insurance and enrolled their children in CHIP.²² With the ACA, many Americans may replace their employer-sponsored health care with Medicaid or federally subsidized coverage purchased on a health insurance exchange. Indeed, some Americans may have

17. *Id.* at 6 & n.11. The difference in findings reflects different ways to measure hospital charges. Chapin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 HEALTH AFF. 935, 941 (2013).

18. *Id.* at 941. To be sure, reductions in fees for hospital care may still lead to increases in spending if hospitals compensate for the lower reimbursement rates by increasing the volume of services provided. *Id.* at 941–42.

19. See Chapin White & Tracy Yee, *When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care*, 32 HEALTH AFF. 1789, 1794 (2013).

20. *Id.*

21. See Matt Broaddus & January Angeles, *Medicaid Expansion in Health Reform Not Likely to “Crowd Out” Private Insurance*, CTR. ON BUDGET & POLICY PRIORITIES (June 22, 2010), <http://www.cbpp.org/cms/?fa=view&id=3218> (addressing the debate over whether the new law will “shift people who already have private coverage to Medicaid” and concluding that it will not). *But see* Richard Kronick & Todd Gilmer, *Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?*, HEALTH AFF., Jan. 2002, at 225, 235 (concluding that pre-ACA expansion of public coverage in four states led to crowding out “among persons with incomes 100–200 percent of poverty”).

22. See Lisa Dubay & Genevieve Kenney, *The Impact of CHIP on Children’s Insurance Coverage: An Analysis Using the National Survey of America’s Families*, 44 HEALTH SERVICES RES. 2040, 2053–54 (2009) (noting that CHIP led to both a 14%–20% increase in public coverage and a 7% decline in employer-sponsored insurance).

no choice but to make such a switch. For some companies, it will make a good deal of economic sense to stop providing health care coverage as an employee benefit and let their workers receive health care coverage as an ACA benefit. Consider, for example, a business that mostly employs low-income workers. If the workers can receive health care coverage for free or at a very low cost, the employer can drop health care coverage without having to compensate employees with higher wages.²³

A substantial crowd-out effect could raise serious problems for the viability of the ACA. When public programs displace private purchases, the public fisc takes a hit, and, at some point, the increase in costs becomes unsustainable.²⁴ So far, projections by expert analysts do not suggest a major crowd-out problem,²⁵ but projections can miss the mark. Over the next few years, data on the extent of crowd out will be important.

III. THE HALL DATA

Professor Hall provides important information on a number of questions. For example, the “medical loss ratio” requirements have done much good.²⁶ Insurance companies are devoting a higher percentage of their premium dollars to medical care for their customers rather than to administrative overhead or profit.²⁷ The public is getting a bigger bang for its health care buck.

That said, the effects were uneven. The greatest consumer benefit occurred in the individual market, where insurers cut

23. Companies with higher-income employees would not benefit by dropping health care coverage. Their employees would not qualify for subsidies to purchase health care coverage and would demand higher wages to cover their health care insurance costs. See 26 U.S.C. § 36B(b)(3)(A)(i) (2012) (allowing subsidies only where household income is less than or equal to 400% of the federal poverty level). Moreover, the increase in wages would be higher than the savings on health care insurance for the employer since pre-tax dollars are used to pay for employer-sponsored coverage while after-tax dollars would be needed to pay for insurance on an ACA exchange. See CONG. BUDGET OFFICE, CBO AND JCT'S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE 11–16 (2012), available at http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf (contrasting employer-sponsored coverage and individual-purchased exchange coverage).

24. GESTUR DAVIDSON, LYNN A. BLEWETT & KATHLEEN THIEDE CALL, ROBERT WOOD JOHNSON FOUND., PUBLIC PROGRAM CROWD-OUT OF PRIVATE COVERAGE: WHAT ARE THE ISSUES? 11–12 (2004), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2004/rwjf17965/subassets/rwjf17965_1.

25. Thomas Buchmueller, Colleen Carey & Helen G. Levy, *Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?*, 32 HEALTH AFF. 1522, 1522, 1526, 1528 (2013); see also CONG. BUDGET OFFICE, *supra* note 23, at 4–7, 17, tbl.2.

26. Medical loss ratio refers to the “portion of premium dollars a health insurer uses to pay for medical care or for health care quality improvement, as opposed to profits, administrative costs, or sales expenses.” Hall, *supra* note 1, at 1048.

27. *Id.*

both their administrative costs and their profits and thereby substantially reduced their overhead costs.²⁸ In the small and large group markets, administrative cost savings were converted into greater profits.²⁹

Hall also considers the impact of the ACA on health care insurance premiums. So far, concerns that ACA regulations would drive up health care premiums have not materialized. The impact of ACA regulations on premiums has been small.³⁰ Premiums have continued to increase but mostly because doctors and hospitals are providing more care and charging more to provide it rather than because of the ACA.³¹

And early data on exchange premiums are generally reassuring. According to a September 2013 report by the U.S. Department of Health & Human Services (HHS), premiums for single enrollees are generally coming in below earlier projections.³² The HHS report compared actual exchange premiums with an earlier HHS estimate for the average premium nationwide.³³ In most states, average premiums are reportedly below the projected national average, often by more than 20%.³⁴

Averages, however, can mask important variations, and an October 2013 *New York Times* analysis found big differences in health insurance costs between states and among different counties in a state.³⁵ In Georgia, for example, premiums are twice as high in

28. MCCUE & HALL, *supra* note 16, at 4.

29. *See id.* at 4–6.

30. *See* Hall, *supra* note 1, at 1047–48 (noting that premium rate increases “covered only about 5%–10% of the individual and small group markets nationally”).

31. *See id.* (“Medical costs were the main drivers of these increases, based both on increasing use of medical services and increased unit prices.”). Of course, as Hall observes, his analysis is based on data collection that occurred before the ACA’s guaranteed issue and community rating provisions took effect. *Id.* at 1054 (noting that the ACA’s major provisions only came into effect in January 2014 and that at least two years will be required to determine the effects of the ACA’s rules and subsidies).

32. *See* ASPE OFFICE OF HEALTH POLICY, DEPT OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE PREMIUMS FOR 2014, at 2–3, 5 (2013), available at http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf (determining that 95% of “uninsured potentially eligible for the Marketplaces live in states with average premiums below . . . projected premiums”).

33. *See id.* (comparing exchange premiums against CBO premium projections).

34. *See id.* at 5 (finding that at least 39% of uninsured Americans potentially eligible for insurance in the forty-eight states providing premium data can secure premiums 20% or more below the CBO estimate). In a February 2014 report, the CBO lowered its 2014 estimates for exchange-purchased insurance by 15%. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: 2014 TO 2024 app. B, at 114 (2014), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf.

35. Abelson, Thomas & McGinty, *supra* note 6 (observing that varying degrees of competition between insurers in more populous regions versus rural and small town communities can translate into disparities in plan premium costs).

rural Baker County—which is in the southwest corner of the state—as in Atlanta.³⁶ The higher-cost counties and states tend to have only one or two insurers competing for business while the lower-cost counties and states tend to have three or more insurers competing for business.³⁷

While lack of competition is a problem in many parts of the country, Hall's data on the number of insurers suggest that problems with weak competition predate the ACA.³⁸ There have been reductions in the number of insurers since the ACA's enactment, but the reductions are modest.³⁹ The ACA appears to be falling short more by not promoting greater competition than by decreasing the level of competition.

But even if the ACA is not increasing premiums through burdensome regulations or decreased competition among insurers, it may still disappoint. The ACA's goal was not simply to avoid causing health care costs to rise. Its authors sought to “bend the cost curve” so that health care spending would rise more slowly and perhaps even decline over time. So far, it is not clear that the cost-saving provisions in the ACA will have a substantial impact. Indeed, the Centers for Medicare and Medicaid Services estimated that once the ACA was fully implemented, health care spending would rise at an annual rate of 6.7% instead of 6.8%.⁴⁰

And some of the cost-cutting provisions of the ACA may be counterproductive. For example, the ACA encourages the

36. *Id.*

37. *Id.* (providing as an example a comparison of higher-cost Wyoming, with two carriers, and lower-cost Montana, with three).

38. See Hall, *supra* note 1, at 1041–42 (observing that between 2011 and 2012, the number of insurers with at least 1,000 members declined only 11% in the individual market and 6% in the small group market).

39. See *id.* (“[T]here has been only a modest reduction so far in the number of insurers with 1,000 or more members in each market segment.”).

40. Andrea M. Sisko et al., *National Health Spending Projections: The Estimated Impact of Reform Through 2019*, 29 HEALTH AFF. 1933, 1936 (2010) (citing CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2009–2019, at tbl.1 (2010), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/NhE-projections2009to2019.pdf>). Some observers have cited the moderating of health care costs in the past few years as evidence that the ACA is indeed “bending the [cost] curve.” See Paul Krugman, Op-Ed., *Obamacare's Secret Success*, N.Y. TIMES, Nov. 29, 2013, at A33. But the moderation in costs began before enactment of the ACA and more likely reflects other factors, including a reduction in demand for health care by patients because of the economic recession and because of a pre-ACA trend of employers and insurers requiring individuals to pay a higher share of their health care costs. See, e.g., Alexander J. Ryu et al., *The Slowdown in Health Care Spending in 2009–11 Reflected Factors Other than the Weak Economy and Thus May Persist*, 32 HEALTH AFF. 835, 835–38 (2013) (examining job loss and diminished employer plan generosity as factors potentially influencing the health care spending slowdown, but expressing “cautious optimism” that the spending slowdown may be more than temporary).

formation of accountable care organizations (ACOs) as a vehicle for promoting higher-quality, lower-cost care.⁴¹ ACOs bring hospitals, doctors, and other health care providers together to provide integrated health care to patients.⁴² ACOs look a lot like health maintenance organizations (HMOs), and the public rejected the cost-saving policies of HMOs.⁴³ Moreover, rather than driving costs down, ACOs may drive them up.⁴⁴ By promoting consolidation among physicians, hospitals, and other health care providers, ACOs will enjoy much greater market power than their components could exert standing alone.⁴⁵

IV. THE FUTURE OF THE ACA

As we go forward and collect even more data about the impact of the ACA, we will be able to get a better handle on the effectiveness of ACA reforms. In the meantime, we can make some fairly safe assumptions. Almost certainly, the ACA will make the individual health insurance market work better. Insurers will no longer be able to charge higher premiums or deny coverage for people with preexisting medical conditions.⁴⁶ Also, the ACA's subsidies for the purchase of insurance will ensure that coverage is affordable for most purchasers of individual health care plans.⁴⁷ The ACA also will turn Medicaid

41. See 42 U.S.C. § 1395jjj(a)–(b) (2012) (providing for and establishing standards for ACOs).

42. See Thomas L. Greaney, *Accountable Care Organizations: The Fork in the Road*, 364 NEW ENG. J. MED. e1(1), e1(1) (2011), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404> (“ACOs are best understood as affiliations of health care providers that are held jointly accountable for achieving improvements in the quality of care and reductions in spending.”).

43. See David Orentlicher, *The Rise and Fall of Managed Care: A Predictable “Tragic Choices” Phenomenon*, 47 ST. LOUIS U. L.J. 411, 411 (2003); see also Ezekiel J. Emanuel, *Why Accountable Care Organizations Are Not 1990s Managed Care Redux*, 307 JAMA 2263, 2263 (2012). Some observers believe that sufficient differences exist between ACOs and HMOs such that the experience with ACOs will be much better. See *id.* at 2263–64.

44. See Greaney, *supra* note 42, at e1(1)–e1(2) (noting that ACOs may encourage mergers and other joint ventures that increase market concentration and escalate health insurance costs, and citing studies showing that hospital mergers in the 1990s increased inpatient prices anywhere from 5%–40%).

45. See *id.* (observing that “[a]necdotal evidence suggests that health care reform legislation has already prompted a number of mergers among health care providers” and that such market concentration “has been a major factor spurring escalation in the cost of health insurance”).

46. See 42 U.S.C. §§ 300gg–3(a), 300gg–4(b)(1) (prohibiting preexisting condition exclusions or other discrimination based on health status).

47. See *id.* § 18071 (providing for federal subsidies in support of insurance purchases for eligible individuals). Out of a potential market of 28,605,000 residents, more than 17,000,000 will be tax credit eligible. HENRY J. KAISER FAMILY FOUND., STATE-BY-STATE ESTIMATES OF THE NUMBER OF PEOPLE ELIGIBLE FOR PREMIUM TAX CREDITS

into a better program for indigent Americans. By expanding eligibility to include all persons with a family income up to 138% of the federal poverty level,⁴⁸ Medicaid will reach all poor Americans rather than just those who are poor and young, poor and pregnant, poor and a caretaker of children, or poor and disabled.⁴⁹ For the millions of Americans who do not have access to good employer-sponsored insurance and who are too poor to buy their own policy, the ACA will do much good.

However, the ACA will almost certainly fall short in many ways. For example, the ACA will not result in universal access to coverage. The Medicaid expansion and individual market reforms are game changers, but they are not comprehensive in their reach. Insurance will remain too pricey for many people, and gaps in coverage will remain. While making Medicaid and the private insurance market work better are very good reforms, they cannot achieve all that could be achieved by switching to a public insurance program such as Medicare-for-all.⁵⁰

There is an even bigger problem with the orientation of ACA reform. Access to health care insurance is important, but it is important not as an end in itself. Rather it is important as a means to better health. And the link between having health care insurance and being healthy is more tenuous than one might think. It is not difficult to find anecdotes that illustrate the importance of health care coverage,⁵¹ and it is true that people with good health care

UNDER THE AFFORDABLE CARE ACT 3 tbl.1 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8509-state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits.pdf>.

48. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) (establishing Medicaid eligibility for those whose income does not exceed 133% of the poverty line). In addition, 5% of an applicant's income is disregarded, effectively raising the eligibility threshold to 138%. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 7 n.13 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

49. See David Orentlicher, NFIB v. Sebelius: *Proportionality in the Exercise of Congressional Power*, 2013 UTAH L. REV. 463, 466. There is an important caveat to this point. Recall that the U.S. Supreme Court held that states can decline to participate in the Medicaid expansion while still participating in pre-ACA Medicaid. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2603, 2607 (2012). To the extent that states do not participate in Medicaid expansion, many poor persons will continue to lack access to health care insurance.

50. According to estimates, more than 20 million Americans will remain uninsured even if every state adopts the Medicaid expansion. See CBO's *Analysis of the Major Health Care Legislation Enacted in March 2010: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 112th Cong. 17 (2011) (statement of Douglas W. Elmendorf, Director, Cong. Budget Office), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf>. Many of those who will remain uninsured are undocumented immigrants. *Id.*

51. See, e.g., Michael Stillman & Monalisa Tailor, *Dead Man Walking*, 369 NEW ENG. J. MED. 1880, 1880 (2013) (describing a patient whose cancer diagnosis was delayed for many

insurance are healthier than are the uninsured. For example, one study found that the uninsured have a mortality rate 40% higher than that of the insured.⁵² Another study found that having health insurance increased the likelihood that a person would report a very good or excellent health status.⁵³

Nevertheless, the insured and uninsured differ in many important ways other than in their access to health care, including wealth and education. These other differences may explain differences in health much more than do the differences in health insurance status.

Indeed, a study from Oregon suggests that insurance matters less than expected. In 2008, Oregon was able to expand its Medicaid program, but only for a limited number of persons.⁵⁴ While there was a waiting list of almost 90,000 people for the Medicaid program,⁵⁵ there were only slots for only about 10,000 additional people.⁵⁶ The State decided to allocate the new slots through a lottery.⁵⁷ As a result, Oregon effectively created a randomized controlled study of the benefits of Medicaid coverage. Applicants who won the lottery and received Medicaid coverage could be compared with applicants who lost the lottery and remained uninsured.

In 2013, researchers reported their first round of data on health outcomes,⁵⁸ and the results were sobering. The study analyzed data for the first two years of the expansion, and the researchers looked at outcomes for persons with high blood pressure, elevated cholesterol, diabetes, or depression.⁵⁹ Medicaid coverage resulted in greater utilization of the health care system,

months because of his inability to afford care); Allan R. Gold, *The Struggle to Make Do Without Health Insurance*, N.Y. TIMES, July 30, 1989, at 1 (relating stories of uninsured Americans, including one of a pregnant woman who attempted to drive eighty-four miles during labor to a free clinic, which led to severe brain damage and the eventual death of her child).

52. Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2293 tbl.2 (2009).

53. See Jack Hadley & Timothy Waidmann, *Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries*, 41 HEALTH SERVICES RES. 429, 442 (2006) (finding increases in very good health status from 29.8% to as much as 33.9%, and from 13.3% to as much as 16.6% for excellent health status).

54. Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q.J. ECON. 1057, 1063 (2012) (explaining that state budget constraints limited Oregon's Medicaid expansion efforts).

55. *Id.* at 1058, 1063. Not everyone on the waiting list actually satisfied all of the eligibility requirements of the Medicaid program. *Id.* at 1064.

56. *Id.* at 1063.

57. *Id.*

58. See Katherine Baicker et al., *The Oregon Experiment: Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1715–18 (2013) (surveying over 12,000 people covered by Medicaid for a range of clinical conditions).

59. *Id.* at 1714–15.

more individual self-reports of better health, and less financial strain.⁶⁰ However, there was no reduction in levels of hypertension, high cholesterol, or diabetes.⁶¹ There was a reduction in levels of depression, but no increase in the extent to which participants reported being happy.⁶² Perhaps it takes more than two years to show significant benefits from being insured, but one would have expected more of an impact from the Medicaid expansion.

Another careful study also casts doubt on the link between insurance status and health. The study collected data on people nationwide who were age 50–61 in 1992 and looked at their health outcomes for the next 18 years.⁶³ While insured individuals used more health care resources than did uninsured persons, there was no evidence that being insured lowered the risk of death 12–14 years into the study and only mild evidence of a mortality benefit at 16–18 years.⁶⁴ 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.⁶⁵ By 16–18 years into the study, everyone would have become a Medicare recipient, and many of the study subjects would have become Medicare eligible much earlier.⁶⁶ Indeed, the oldest study subjects would have spent 14 out of their 18 study years on Medicare.⁶⁷ 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.⁶⁸ Other study results suggest that the lower risk of death for the insured resulted from factors other than insurance status. For example, people who had public insurance had higher mortality rates than did the uninsured.⁶⁹

To be sure, other studies have found improvements in health status that were related to improvements in insurance status. In

60. *Id.* at 1717–18.

61. *Id.* at 1715–16 (finding, however, an increase in the diagnosis rate and “us[e] of medications for diabetes”).

62. *Id.* at 1716–18.

63. Bernard Black et al., *The Effect of Health Insurance on Near-Elderly Health and Mortality* 7, 17 (Northwestern Univ. Law Sch., Law and Econ. Research Paper No. 12-09, 2013), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2103669. The authors looked at this “near-elderly” population because a beneficial effect of insurance would most likely be found in that group—younger people are healthier, and older people are covered by Medicare. *Id.* at 1.

64. *Id.* at 1–2, 7, 15–19.

65. *Id.* at 2, 24.

66. *Id.* at 7.

67. *See id.* at 3.

68. *Id.* at 15, 22 & n.31.

69. *Id.* at 15. Public insurance included Medicaid, Medicare, and Veterans Affairs health care. *Id.* at 8.

one study, for example, researchers compared three states that had expanded their Medicaid programs between 2000 and 2005 to include “childless adults” with neighboring states that were similar demographically but had not undertaken similar expansions of their Medicaid programs.⁷⁰ The states with the expansions saw a significant reduction in mortality rates compared to the neighboring states.⁷¹ Another study found a significant decrease in mortality rates for patients with emergency needs for health care once Medicare kicked in at age sixty-five.⁷²

But none of the studies finding benefits from access to health care insurance involved the rigor of the Oregon Medicaid study. That is, because they were not randomized controlled studies, the differences in health status between insured and uninsured persons may have reflected factors other than differences in insurance status.⁷³

There are other good reasons to discount the studies finding a health benefit from insurance. In the Medicaid expansion study, only one of the three expansion states experienced a significant decrease in mortality,⁷⁴ and the decline was too large to be explained by the reduction in the number of uninsured.⁷⁵ Similarly, in the study of Medicare patients with emergency needs for health care, the decrease in mortality was too large to be explained by changes in care for the small percentage of Americans who moved from being uninsured to being insured at age sixty-five.⁷⁶

Other data also suggest that the connection between health care insurance and health is more tenuous than one might expect. Researchers have studied health outcomes in England under that country’s universal National Health Service (NHS), and the data indicate that socioeconomic status is much more important for health than is access to health care.⁷⁷ For example,

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

71. *Id.* at 1029–31.

72. David Card, Carlos Dobkin & Nicole Maestas, *Does Medicare Save Lives?*, 124 *Q.J. ECON.* 597, 597, 621–24 (2009).

73. Sommers, Baicker & Epstein, *supra* note 70, at 1032.

74. That is, while there was a significant mortality decrease when the expansion states were compared as a group with the neighboring states, there was a significant decrease in only one state when each state was compared separately with its neighboring state(s).

75. Black et al., *supra* note 63, at 6.

76. Card, Dobkin & Maestas, *supra* note 72, at 597–98, 632–33.

77. Michael Marmot, *Multilevel Approaches to Understanding Social Determinants*, in *SOCIAL EPIDEMIOLOGY* 349, 365 (Lisa F. Berkman & Ichiro Kawachi eds., 2000); see *The History of the NHS in England*, NHS, <http://www.nhs.uk/NHSEngland/thenhs/nhshistory/Pages/NHShistory1948.aspx> (last updated June 24, 2013).

the higher the socioeconomic status of a person, the lower the mortality rate.⁷⁸ People in the highest civil service grade for government employees have a mortality rate about half that of people in the lowest civil service grade, even though they all have good access to health care.⁷⁹ In addition, the gap in mortality rates among men in England by socioeconomic status has actually widened over time since the introduction of the NHS in 1948.⁸⁰

A number of other studies reinforce the link between socioeconomic status and health status. These studies have found that improvements in socioeconomic status lead to improvements in health status. For example, consider an interesting policy experiment in Canada during the 1970s.⁸¹ For four years, the province of Manitoba guaranteed a minimum annual income for all residents of Dauphin, a small, rural city.⁸² At any one time, only about a third of the city's residents received payments from the provincial government, and for many of those people, the payments were small.⁸³ Nevertheless, everyone benefited from the program in the sense that it provided "income security"—everyone knew that whatever happened to their income stream, they could expect a basic annual income. This security would have been particularly valuable in Dauphin because it was an agricultural community where incomes depended on harvest sizes and commodity prices that could vary substantially from year to year.⁸⁴ Thus, for example, farming families could be more comfortable letting their older children remain in school rather than work at home.⁸⁵

With the income security from the Manitoba policy, health status improved significantly. When Dauphin residents were compared with residents of other rural communities in Manitoba,

78. Marmot, *supra* note 77, at 349–50.

79. *Id.* at 349–51 & tbl.15-1. Taking into account differences in smoking rates, cholesterol, blood pressure, exercise, and height explained no more than a third of the gradient. *Id.* at 362–63 & fig.15-10.

80. Gopal Sreenivasan, *Health Care and Equality of Opportunity*, HASTINGS CENTER REP., Mar.–Apr. 2007, at 21, 25–26 (citing Douglas Black et al., *The Black Report*, in *INEQUALITIES IN HEALTH* 29, 59 tbl.7 (Peter Townsend & Nick Davidson eds., 3d ed. 1992)); Margaret Whitehead, *The Health Divide*, in *INEQUALITIES IN HEALTH*, *supra*, at 215, 231.

81. Evelyn L. Forget, Commentary, *The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment*, 37 CANADIAN PUB. POL'Y 283, 289 (2011).

82. *Id.* at 288–90. Some residents of Winnipeg also received a guaranteed minimum income. *Id.*

83. *Id.* at 291.

84. *See id.* at 289–90.

85. *See id.* at 291–92.

the data showed that while people in Dauphin were more likely to be hospitalized before implementation of the minimum income program, the gap in hospitalization rates disappeared by the end of the program.⁸⁶ This decline largely occurred for hospitalizations that tend to be sensitive to levels of income security.⁸⁷ For example, accidents and injuries are more common for people who are income insecure.⁸⁸ Income insecurity makes people more likely to continue working when fatigued, increase their alcohol intake, or not hire caretakers who can protect their children from accidents.⁸⁹ Just as overall hospitalization rates were higher in Dauphin before the minimum income program, so were hospitalizations for accidents and injury, and just as the gap in overall hospitalization rates disappeared during the program, so did the gap in hospitalizations for accidents and injuries.⁹⁰ The results were the same for hospitalizations for anxiety disorders, depression, and other mental health conditions.⁹¹ In sum, providing income security to Dauphin residents made them less likely to need hospital care.

Note that the improvements in health status cannot be attributed to better access to health insurance. One might wonder whether providing a minimum income made it more possible for poor residents of Dauphin to purchase health care coverage. However, Manitoba had implemented a program of universal health insurance before the minimum income experiment, so the income benefits did not affect health insurance status.⁹²

Other studies also illustrate the value of socioeconomic interventions for promoting health. In one U.S. study, chronically homeless individuals with serious alcohol abuse problems were given housing.⁹³ Previous studies had shown that the provision of housing reduced hospital admissions and shortened the duration of hospitalizations for homeless persons.⁹⁴ This study found that health care costs dropped by more than 50% in the first six

86. *Id.* at 294–95 & fig. 2.

87. Evelyn L. Forget, *New Questions, New Data, Old Interventions: The Health Effects of a Guaranteed Annual Income*, 57 PREVENTIVE MED. 925, 926–27 (2013).

88. Sandra J. McIsaac & Richard G. Wilkinson, *Income Distribution and Cause-Specific Mortality*, 7 EUR. J. PUB. HEALTH 45, 49 & tbl.6 (1997).

89. Forget, *supra* note 81, at 296.

90. *Id.* at 295–97.

91. *Id.* at 297.

92. *Id.* at 299.

93. Mary E. Larimer et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 JAMA 1349, 1350 (2009).

94. *Id.* at 1349.

months after the chronically homeless persons were placed in their new homes,⁹⁵ and health care costs continued to be lower through the full twelve months of the study.⁹⁶

Why might socioeconomic status be much more important than health insurance status for health? Does health care not matter for health status? No, health care does matter.⁹⁷ Undoubtedly, the health of uninsured persons would be worse if they lacked access to health care entirely. But the uninsured receive some care, whether in emergency departments, other hospital settings, free clinics, or community health centers. Having good insurance makes for more health care, but not necessarily for better health.⁹⁸ Indeed, more health care can be harmful to one's health. Many people with good insurance receive care that in hindsight turns out to provide no benefit but significant risks to health (e.g., postmenopausal women who received hormone-replacement therapy).⁹⁹ In addition, it may be true that health insurance is a necessary, but not sufficient, factor in improving a person's health. That is, the uninsured face many barriers to receiving good health care, and they often may need other kinds of assistance to ensure that they realize the full benefits of health care coverage. For example, patients who are poor and poorly educated may need help navigating the health care system.¹⁰⁰

Even to the extent that health care makes for better health, the impact of more health care is limited. It is not at all surprising that the ACA may fall short in terms of improving people's health. The ACA put most of its money on treatment,¹⁰¹ and that was not a wise bet. It has long been clear that public health interventions do far more to promote health than do treatments of disease.¹⁰²

95. *Id.* at 1353 (reporting that “[i]ndividual median costs” decreased from \$4,066 per month to \$1,492 per month over a six-month period).

96. *Id.*

97. According to one estimate, medical care was responsible for about one-sixth of the increase in life expectancy between 1900 and 1995 in the United States and about one-half of the increase between 1950 and 1995. John P. Bunker, *The Role of Medical Care in Contributing to Health Improvements Within Societies*, 30 INT'L J. EPIDEMIOLOGY 1260, 1261 (2001).

98. Black et al., *supra* note 63, at 3.

99. *Id.* at 22, 24.

100. Harold P. Freeman, Op-Ed., *Why Black Women Die of Cancer*, N.Y. TIMES, Mar. 14, 2014, at A27.

101. See CBO's *Analysis of the Major Health Care Legislation Enacted in March 2010*, *supra* note 50, at 3 (statement of Douglas W. Elmendorf, Director, Cong. Budget Office) (recognizing that the ACA's budget increases serve to expand health care coverage while other provisions reduce spending and increase revenue).

102. Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590, 590 (2010).

For example, better funding of tobacco cessation programs would do much to reduce cigarette smoking and the cancers or other diseases that it causes in smokers. The ACA provides some funding for tobacco cessation through its Prevention and Public Health Fund,¹⁰³ but the fund was supposed to provide only \$2 billion a year for all programs, including tobacco cessation, by 2015; Congress already has cut back on the amount of funding, so the fund will not reach the \$2 billion level until 2022.¹⁰⁴ With more dollars, the ACA could have ensured that each state meets the Centers for Disease Control and Prevention's recommended level of spending for tobacco cessation programs. While recommended spending for all states is less than \$4 billion per year, states only spend 13% of the recommended amount, according to a December 2013 report.¹⁰⁵

In addition to improving the health of smokers, better tobacco legislation could protect nonsmokers. In particular, second-hand smoking bans in states without them would do much to reduce hospital admissions for heart attacks, strokes, and asthma among nonsmokers.¹⁰⁶ The ACA could have given states financial incentives to pass second-hand smoking bans.

To be sure, the ACA does not ignore public health needs, and some of its provisions will be very helpful. For example, health insurance must cover the full costs of immunizations, colonoscopies, mammograms, tobacco cessation treatments, and other important preventive measures.¹⁰⁷ In addition, the Prevention and Public Health Fund will provide valuable support even though its eventual \$2 billion per year is not a substantial amount of money.

103. 42 U.S.C. § 300u-11 (2012); *see also* AM. LUNG ASS'N, TOBACCO CONTROL AND THE PREVENTION AND PUBLIC HEALTH FUND 1 (2012), *available at* <http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/2012/factsheet-prevention-and-public-health-fund.pdf>.

104. *Prevention and Public Health Fund*, AM. PUB. HEALTH ASS'N, <http://www.apha.org/advocacy/Health+Reform/PH+Fund/> (last visited Feb. 23, 2014). In its 2014 fiscal year budget, Congress eliminated all of the fund's allocation for that year. Eric Lipton & Jonathan Weisman, *\$1.1 Trillion Bill to Avoid Federal Shutdown Covers Many Local Interests*, N.Y. TIMES, Jan. 15, 2014, at A16.

105. CAMPAIGN FOR TOBACCO-FREE KIDS, BROKEN PROMISES TO OUR CHILDREN: THE 1998 STATE TOBACCO SETTLEMENT 15 YEARS LATER i, x (2013), *available at* http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2014/StateSettlementReport_FY2014.pdf; CTRS. FOR DISEASE CONTROL & PREVENTION, DEP'T OF HEALTH & HUMAN SERVS., BEST PRACTICES FOR COMPREHENSIVE TOBACCO CONTROL PROGRAMS 54 (2007), *available at* ftp://ftp.cdc.gov/pub/fda/fda/BestPractices_Complete.pdf.

106. Dariush Mozaffarian et al., *Population Approaches to Improve Diet, Physical Activity, and Smoking Habits: A Scientific Statement From the American Heart Association*, 126 CIRCULATION 1514, 1546 (2012).

107. 42 U.S.C. § 300gg-13(a); *see also* *Preventive Services Covered Under the Affordable Care Act*, DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html> (last updated Sept. 27, 2012).

But other ACA provisions that are designed to promote health rather than treat disease were poorly chosen. For example, there are two key sections for wellness—the menu labeling requirements for restaurants and the provisions encouraging employer wellness programs.¹⁰⁸ Unfortunately, the evidence suggests that the two provisions may cause more harm than good.¹⁰⁹

The menu labeling mandate requires restaurants to disclose calorie information for its foods and beverages,¹¹⁰ and it responds to an important gap in food labeling laws. While foods purchased at a grocery store have carried nutritional labeling since the 1990s,¹¹¹ foods purchased at restaurants generally have not. And Americans are eating more of their meals away from their homes than they did in the past.¹¹² With restaurant meals “typically higher in calories and fat” than meals made at home,¹¹³ many people may be eating too much because they are not aware of how many calories they are consuming. Even ostensibly healthy dining options, such as salads, can contain calorie amounts that exceed those of a McDonald’s Big Mac.¹¹⁴ The ACA’s menu labeling mandate rests on a sensible premise—people will make healthier meal choices when they are better informed about the calorie contents of the different menu options.

But it turns out that more information about caloric content does not result in lower calorie intake.¹¹⁵ Other factors are much

108. 21 U.S.C. § 343(q)(5)(H); 42 U.S.C. § 300gg-4(j).

109. For more discussion of this point, see David Orentlicher, *Health Care Reform and Efforts to Encourage Healthy Choices by Individuals*, 92 N.C. L. REV. (forthcoming 2014). See also Micah L. Berman, *A Public Health Perspective on Health Care Reform*, 21 HEALTH MATRIX 353, 367–68, 374–77 (2011).

110. 21 U.S.C. § 343(q)(5)(H). The definition of “food” includes beverages. *Id.* § 321(f)(1).

111. Nutrition Labeling and Education Act of 1990, Pub. L. No. 101-535, 104 Stat. 2353 (codified as amended at 21 U.S.C. § 343(q)).

112. HAYDEN STEWART, NOEL BLISARD & DEAN JOLLIFFE, ECON. RESEARCH SERV., LET’S EAT OUT: AMERICANS WEIGH TASTE, CONVENIENCE, AND NUTRITION 1 (2006), available at <http://www.ers.usda.gov/ersDownloadHandler.ashx?file=/media/860870/eib19.pdf> (“USDA’s food intake surveys show that between 1977–78 and 1994–96, the share of daily caloric intake from food away from home increased from 18 percent to 32 percent.”).

113. Sara N. Bleich & Lainie Rutkow, *Improving Obesity Prevention at the Local Level—Emerging Opportunities*, 368 NEW ENG. J. MED. 1761, 1761 (2013).

114. *Compare McDonald’s USA Nutrition Facts for Popular Menu Items*, MCDONALD’S, <http://www.nutrition.mcdonalds.com/getnutrition/nutritionfacts.pdf> (last visited Feb. 23, 2014) (showing that a Big Mac contains 550 calories), with *Nutrition Facts*, JACK IN THE BOX, http://www.jackinthebox.com/food/documents/nutritional_facts_document (last visited Feb. 23, 2014) (showing that a Chicken Club Salad with crispy chicken strips and bacon ranch dressing can exceed 700 calories).

115. Berman, *supra* note 109, at 367–68; Orentlicher, *supra* note 109.

more important than nutritional information. For example, it is difficult for many people to decline the immediate enjoyment of high-calorie food for the delayed benefit of a longer lifespan.¹¹⁶ The government needs to do much more than require the disclosure of calorie information if it wants to change the dietary habits of Americans.

The menu labeling mandate may not provide much benefit, but the wellness program provisions may actually cause harm—those provisions may undermine the ACA’s goal of making health care coverage affordable.¹¹⁷ Wellness programs include questionnaires about diet and exercise and measurements of weight, blood pressure, and other markers of health to identify when people are at risk for poor health.¹¹⁸ Wellness programs also include counseling about diet and exercise, smoking cessation programs, and other interventions to help people lower their risks for poor health.¹¹⁹ So far, so good. But employers are permitted to establish targets for their employees to attain, such as lower weight, lower blood pressure, or lower blood sugar, and penalize those employees who fail to meet their targets by a health insurance premium surcharge of up to 30% of the cost of an individual insurance policy.¹²⁰ In other words, people with preexisting medical conditions may have to pay 30% more for their health care insurance than is paid by people without

116. Kristin M. Madison, Kevin G. Volpp & Scott D. Halpern, *The Law, Policy, and Ethics of Employers’ Use of Financial Incentives to Improve Health*, 39 J.L. MED. & ETHICS 450, 452–54 (2011); Ted O’Donoghue & Matthew Rabin, *The Economics of Immediate Gratification*, 13 J. BEHAV. DECISION MAKING 233, 234 (2000).

117. See Berman, *supra* note 109, at 374–77 (arguing that the wellness program provisions will impose significant costs on individuals with preexisting conditions in contravention of the ACA’s main purpose); Orentlicher, *supra* note 109.

118. SOEREN MATTKE ET AL., WORKPLACE WELLNESS PROGRAMS STUDY: FINAL REPORT 21 (2013).

119. *Id.* at 21–23.

120. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33,176–77, 33,191 (June 3, 2013) (to be codified at 46 C.F.R. pts. 146 and 147). Thus if the total cost of coverage (including employer and employee contributions) is \$5,000, an employer could employ financial incentives up to \$1,500. If family members are eligible for the financial incentives, then the maximum incentive would be 30% of the cost of family coverage. In addition to capping the amount of financial incentives, the ACA includes other protections for employees. For example, ACA regulations “require that health-contingent wellness programs be reasonably designed to promote health or prevent disease,” “not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease.” *Id.* at 33,159, 33,162; see also Jill R. Horwitz, Brenna D. Kelly & John E. DiNardo, *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFF. 468, 470 (2013). The ACA also allows the Secretaries of Labor, Health and Human Services, and the Treasury to raise the incentive cap from 30% to 50%. Madison, Volpp & Halpern, *supra* note 116, at 451 (citing 42 U.S.C. § 300gg-4(j)(3)(A) (2012)).

preexisting conditions. Ironically, as the ACA eliminates preexisting condition surcharges in the individual market,¹²¹ it encourages premium variations in the group market on the basis of personal health status. Discrimination on the basis of preexisting conditions may appear in group plans as it disappears in individual plans.¹²²

V. CONCLUSION

What can we draw from all of this? It may be that the benefits of the ACA lie much more on their benefit for economic health than physical health. Support for the ACA was driven in large part by concerns about the extent to which health care costs were overwhelming family budgets.¹²³ Much attention was paid to the fact that costly medical care was forcing many Americans into bankruptcy.¹²⁴ According to one estimate, medical bills played a significant role in more than half of all personal bankruptcies in 2007.¹²⁵ The ACA will greatly reduce the financial burden on Americans caused by health care needs, and this is valuable.¹²⁶

121. 42 U.S.C. § 300gg-3(a).

122. Matt Lamkin, *Health Care Reform, Wellness Programs and the Erosion of Informed Consent*, 101 KY. L.J. 435, 444–45 (2013). The Americans with Disabilities Act (ADA) does not appear to offer much protection from these premium surcharges. Under the ADA, insurance enjoys a generous exemption from the Act's antidiscrimination provisions. *Id.* § 12201(c); see *Seff v. Broward Cnty.*, 691 F.3d 1221, 1223–24 (11th Cir. 2012); Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 NEW ENG. J. MED. 192, 194–95 (2008).

123. President Barack Obama, Remarks by the President on the Affordable Care Act (May 10, 2013) (transcript available at <http://www.whitehouse.gov/the-press-office/2013/05/10/remarks-president-affordable-care-act>) (remarking that the ACA was created in part to relieve “the stress of trying to manage a family budget when health care costs are impinging on it”).

124. See, e.g., Jim Dwyer, *Without Health Care, One Burger from Ruin*, N.Y. TIMES, Sept. 13, 2009, at MB1; Nicholas D. Kristof, *Until Medical Bills Do Us Part*, N.Y. TIMES, Aug. 30, 2009, at WK8; Kevin Sack, *From the Hospital Room to Bankruptcy Court*, N.Y. TIMES, Nov. 25, 2009, at A1.

125. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009).

126. Krugman, *supra* note 40. For many people, however, financial burdens will remain even after the ACA is fully implemented. The subsidies to purchase individual plans on health insurance exchanges phase out at 400% of the federal poverty level, and some people just above 400% of the poverty level will have trouble affording their health insurance. 26 U.S.C. § 36B(b)(3)(A)(i); see also Richard Kirsch, *The Politics of Obamacare: Health Care, Money, and Ideology*, 81 FORDHAM L. REV. 1737, 1745–46 (2013). In addition, deductibles are quite high in many of the health exchange plans, and satisfying the deductibles will be a problem for a number of people. Pear, *supra* note 2.

There is a second important way that the ACA will benefit the economic health of Americans. The United States currently suffers from a high degree of income inequality. The share of national income received by the 10% of families with the highest incomes has reached an all-time high since data were first collected in 1917.¹²⁷ For the first time, the top 10% of families take in more than 50% of total national income.¹²⁸ And of the total growth in income since the Great Recession, the top 1% of families claimed 95% of the increase (people who take in more than \$394,000 a year).¹²⁹ High levels of income inequality slow economic growth, stifle socioeconomic mobility, and fuel political polarization.¹³⁰ While government policies over the past few decades have contributed to the growth in income inequality (e.g., through the reduction in income tax rates at the high end), the ACA provides an important degree of wealth redistribution.¹³¹ For example, there will be an additional 0.9% Medicare payroll tax on earnings above \$200,000/\$250,000.¹³² These high earners also are subject to the full 3.8% Medicare payroll tax on the lesser of their net investment income and the amount of their earnings above the \$200,000/\$250,000 level.¹³³ For the average household taking in more than \$1 million this year, the tax bill will rise by \$46,000.¹³⁴ The ACA's contribution to income equality may do much to improve the welfare of all Americans.

I will close with some observations about the highly controversial nature of the ACA.¹³⁵ Clearly, a large part the opposition reflects the fact that we live in a highly polarized political environment. Support of or opposition to the ACA by

127. Emmanuel Saez, *Striking it Richer: The Evolution of Top Incomes in the United States* (Updated with 2012 Preliminary Estimates) 1 (Sept. 3, 2013) (unpublished manuscript), available at <http://elsa.berkeley.edu/~saez/saez-UStopincomes-2012.pdf>.

128. *Id.*

129. *Id.* at 3–4.

130. David Brodwin, *Suffering Under the Weight of Inequality*, U.S. NEWS & WORLD REPORT (Sept. 12, 2013), <http://www.usnews.com/opinion/blogs/economic-intelligence/2013/09/12/record-high-income-inequality-threatens-us-growth>; see also ANDREW G. BERG & JONATHAN D. OSTRY, IMF, *INEQUALITY AND UNSUSTAINABLE GROWTH: TWO SIDES OF THE SAME COIN?* 9, 11, 17 (2011), available at <http://www.imf.org/external/pubs/ft/sdn/2011/sdn1108.pdf>.

131. David Leonhardt, *In the Process, Pushing Back at Inequality*, N.Y. TIMES, Mar. 24, 2010, at A1.

132. 26 U.S.C. § 3101(b)(2) (2012). The \$200,000 threshold applies to individual taxpayers, while the \$250,000 threshold applies to people filing a joint tax return. *Id.*

133. *Id.* § 1411(a)–(b).

134. Leonhardt, *supra* note 131.

135. More than 3.5 years after the ACA's enactment, more than half of all Americans still disapproved of the law, including more than half of the uninsured. See Abby Goodnough & Allison Kopicki, *Uninsured Skeptical of Health Care Law in Poll*, N.Y. TIMES, Dec. 19, 2013, at A1.

members of Congress and the public has reflected party affiliation much more than the substance of the ACA.¹³⁶

But I also worry that the ACA is controversial because it seems to depart from the traditional model for federal health programs. Historically, coverage has been provided not to everyone, but only to those who are viewed as being “deserving” of assistance.¹³⁷ Medicare is a program for seniors who have greater health care needs because of their age and a diminished ability to afford health care costs because of retirement. In other words, seniors need help with their medical care costs through no fault of their own. Moreover, seniors have contributed to their Medicare benefits through payroll deduction while working.¹³⁸ Medicaid originally was a program for the poor who were children, pregnant, caretakers of children, or disabled. Medicaid also was designed as a program for those who were unable to afford health care through no fault of their own. Medicaid recipients “were seen as not responsible for their predicament, either because of age or infirmity or because of their childcare obligations.”¹³⁹

The ACA seems to depart from the “deserving of assistance” paradigm by providing assistance for all persons who do not receive health coverage from their employers and cannot afford the coverage on their own. The ACA makes these individuals eligible for Medicaid or eligible for subsidized private health care insurance.

An important question is whether ACA beneficiaries will be viewed over time as sufficiently deserving of their assistance because health care costs are unaffordable even for

136. The U.S. Senate passed the ACA in a strict party-line vote. Robert Pear, *Senate Approves Health Care Bill in Party-Line Vote*, N.Y. TIMES, Dec. 25, 2009, at A1. Not one Republican in the U.S. House of Representatives voted for the ACA, while 87% of Democrats did. See Robert Pear & David M. Herszenhorn, *House Votes on Party Lines, 219 to 212*, N.Y. TIMES, Mar. 22, 2010, at A1. Public polling also shows substantial differences by party affiliation. While 75% of Democrats approved of the ACA in December 2013, only 10% of Republicans did. Frank Newport, *Americans Slightly Less Negative About Healthcare Law*, GALLUP (Dec. 13, 2013), <http://www.gallup.com/poll/166283/americans-slightly-less-negative-healthcare-law.aspx>.

137. David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 330–31 (2012); see also Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1111 (2003) (noting that public sympathy for the “poorer” and “sicker” elderly led to older Americans receiving national health care insurance ahead of younger citizens).

138. Orentlicher, *supra* note 137, at 329.

139. *Id.* at 331; see also Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 418 (2004) (observing that the original Medicaid beneficiaries included children and their caretakers, the elderly, and disabled groups “deemed too vulnerable to provide insurance for themselves”).

many gainfully employed members of the middle class (e.g., the medical bankruptcy problem), or whether the ACA will begin to unravel as persons with means become less willing to help pay for the health care of those at lower levels of income and wealth.
