Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System

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I. Introduction

No legislation worth its salt is noncontroversial.

The Patient Protection and Affordable Care Act ("Affordable Care Act")\(^1\) is a testament to this proposition. Signed into law in the wake of what surely was one of the most dramatic legislative battles in the history of United States social welfare legislation, the Affordable Care Act fundamentally alters the key legal relationships that undergird the American health insurance system in order to achieve greater equity in health care itself.

What makes a piece of legislation controversial? In a sense, virtually all outcomes of the legislative process stir some controversy, since the process generates results through political conflict. But even a cursory examination of the history of national health reform in the U.S. drives home the magnitude of the drama that historically has surrounded virtually every effort to achieve a major shift in public policy.\(^2\) Part of the problem is Americans’ moral ambivalence over using governmental

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\(^2\) See, e.g., SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS (Harvard Univ. Press 1997); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (Basic Books 1982); JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE (Oxford Univ. Press 2005); See generally LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO
interventions to aid others, a key aspect of redistributive legislation such as the Affordable Care Act. In her seminal reflection on the social and moral importance of governmental response to human need, Deborah Stone reminds us that, “The character of our community is defined by our collective response to other people’s troubles.”

Yet, political scientist James Morone suggests that embedded in the American psyche is a belief that government actions to blunt the worst effects of unregulated markets amounts to an official sanctioning of sloth and bad individual choices. The Affordable Care Act soars into the highest realms of political controversy because it represents such a significant effort to reallocate health care resources toward the poor and uninsured to enable some thirty-two million Americans to gain coverage by January 2014, while also protecting us all against the potential for a future denial, loss, or lapse of coverage. The Act achieves this result through an epic legislative realignment of social relationships: between individuals and the health care system; between employers and workers; between health insurers and the market for coverage; and between the federal and state governments. These legislative realignments involve a new system of tax subsidies for low and moderate income families excluded from the current system of employment-based tax breaks. It also involves a revamping of Medicaid to end its historic exclusion of millions of the nation’s poorest residents because of family composition and economic circumstances somewhat better than the direst poverty.

The passage of the Affordable Care Act was a fraught affair. Rather than

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6 See infra notes 79-86 and accompanying text (discussing the impact and breadth of the proposed reforms).
7 See Jon R. Gabel, Job-Based Health Insurance, 1977-1998: The Accidental System under Scrutiny, 18 Health Affairs 62, 63 (1999) (examining the history of “job-based” health insurance coverage for workers); see also id. at 71 (examining the future of worker health insurance coverage as created and prolonged by employer contributions).
8 See Sara Rosenbaum, Medicaid and National Health Reform, 361 New Eng. J. Med. 2009, 2009-12 (2009) (discussing the Medicaid system and its shortcomings, specifically in its disproportionate or often lack of coverage provided for “the poor and the sick”).
9 See Jacobs & Skocpol, supra note 2, at 1-7 (chronicling the deliberations had and struggles that were encountered in the passage of the Affordable Care Act by President Obama and his colleagues in the legislature).
abating, the controversy has escalated during the early implementation process,\(^\text{10}\) helping fuel a 2010 midterm “wave” election (that is, an election that brings a seminal shift in the political landscape),\(^\text{11}\) the likes of which has not been seen for a half century.\(^\text{12}\) Consistent with expectations,\(^\text{13}\) Republicans successfully employed both the substance of the Act and the legislative process itself\(^\text{14}\) as compelling justifications for fundamental political change. For its part, the Obama Administration (“Administration”) has vacillated between touting the law’s achievements\(^\text{15}\) and attempting to tamp down its toughest terms in an effort to introduce a “go easy” approach to implementation. An example is the Administration’s fall 2010 decision to waive the law’s early restrictions on annual benefit limits aimed at putting a quick end to “mini-med” plans that impose draconian annual benefit caps of as little as $2000 annually.\(^\text{16}\) The waivers effectively


\(^{13}\) See Aaron & Reischauer, *supra* note 10, at 1259 (discussing the Republicans previous expressions of opposition towards the bill).

\(^{14}\) See generally JACOBS & THOPKOL, *supra* note 2, at 111-29.


nullify a key reform slated to take effect in advance of full implementation in 2014. However, it remains to be seen whether these or other concessions will make any difference to the law’s ultimate political fate, along with that of the President and Democratic members of Congress.

The remainder of this article explores the relationships that the Affordable Care Act redefines along its pathway to greater fairness in health care and examines some of the key issues that can be expected to arise as the Administration seeks to transform these redefined legal relationships into enduring achievements.

II. Health Reform and the Transformation of Relationships

As with law generally, social welfare legislation is the formal codification of social relationships. The power of law to transform social codes of conduct into enforceable rights and duties has been long evident in the realm of health and health care policy. Indeed, Social Security and Medicare together create a formal framework for economic and health security for the elderly and workers with significant disabilities. Within this formal framework, employers and workers are compelled to do what some—but by no means all—might have done voluntarily; namely, contribute toward the cost of long-term security. The government, in turn, is bound to contribute toward the cost of the assumed obligations and to administer programs fairly. In this way, the social contract principles on which a civil society rests become legally enforceable guarantees.

Despite the Social Security and Medicare precedents, and the fact that contentiousness seems to be a basic ingredient of social welfare legislation, the challenge of translating socially desirable norms into law reached new heights under the

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17 LAWRENCE M. FRIEDMAN, LAW IN AMERICA 5-10 (Modern Library 2002) (noting American social law builds on “customs, habits, and traditions; but it adds to them the bite and the sting of collective rules and collective enforcement”).


Affordable Care Act. There has been much speculation about the reasons that underlie the Act's bitter reception: a nation in an economic crisis that ranked health reform low on the agenda, preferring priorities that went more directly to the economic and jobs crises; the political deal-making process that became particularly public in a White House focused on avoiding the widespread industry opposition problems encountered by the Clinton Administration; and the Republicans' determined opposition to the legislation, despite its markedly Republican roots. In fact, the Republicans vowed to make health reform the President's political Waterloo, and they succeeded to a remarkable extent in undermining political support for the necessary changes aimed at overcoming the limited nature of employment based coverage.

20 See Sheryl Gay Stolberg & Robert Pear, Obama Signs Health Care Overhaul Bill, With a Flourish, N.Y. TIMES, Mar. 24, 2010, at A19, available at http://www.nytimes.com/2010/03/24/health/policy/24health.html. At the signing of the Patient Protection and Affordable Care Act, President Barack Obama stated, “The bill I'm signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see.” Id. Representative John A. Boehner stated, however, “By signing this bill, President Obama is abandoning our founding principle that government governs best when it governs closest to the people.” Id.

21 For example, in February 2009, when support for the President and Congress was at its highest, one prominent monthly public opinion tracking poll found that reforming health care only ranked fourth among national priorities, well behind improving the country's economic situation. See KAISER HEALTH TRACKING POLL, KAISER FAMILY FOUNDATION, Feb. 2009, available at http://www.kff.org/kaiserpolls/upload/7866.pdf. Cf. Americans See More Priorities Vying for Obama's Attention, GALLUP, http://www.gallup.com/poll/123899/americans-priorities-vying-obama-attention.aspx (last visited Mar. 14, 2011) (finding that although percentage of pollsters ranking health care as a top priority rose in 2009 from five to seven percent, health care still ranked below issues like the economy).


23 The Massachusetts health reform plan, advocated by the then Republican Governor Mitt Romney and enacted into law on a bipartisan basis, served as the prototype for the legislative structure of the Affordable Care Act. See Kavita Patel & John McDonough, From Massachusetts to 1600 Pennsylvania Avenue: Aboard the Health Reform Express, 29 HEALTH AFFAIRS, 1106-11 (2010) (discussing extent to which the Massachusetts model influenced reform at the federal level). Particularly noteworthy are the similarities between the Massachusetts reform law and the Affordable Care Act with respect to the individual mandate to purchase coverage, the mandatory employer contribution requirements, and the establishment of purchasing exchanges. See generally, 2006 MASS. LEGIS. SERV. ch. 58 (West) (enacting individual mandate, establishing pay or play provisions, and creating the Health Care Connector).


25 Sixty-nine percent of all firms offered health benefits to their employees in 2010. See Health
coupled with the lack of alternatives to a weak individual market and the absence of a robust public insurance pathway through Medicaid.\(^{26}\)

The legislative process that led to enactment further intensified resistance to the relationships envisioned by the law: a measure that barely made it through the House of Representatives, despite intense White House and leadership pressure\(^{27}\) a Senate process that dragged on for a year to almost no avail and then lurched to a conclusion on Christmas Eve, 2009; a staged fury at dozens of health reform “town hall” meetings; the dramatic loss of the Senate’s Democratic supermajority in an election involving the seat of an iconic figure who had devoted his career to national health reform;\(^{28}\) the impact of the election on the House/Senate conference agreement process;\(^{29}\) and the final series of “Hail Mary” passes that combined to push the legislation through to enactment.\(^{30}\) At every step of the way, the public was subjected to an echo chamber of misinformation about the legislation, assuring a thorough poisoning of the well by passage.

Comparatively, the political circumstances that gave rise to Medicare differed dramatically in any number of respects from those that surrounded the Affordable Care

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\(^{26}\) See \textit{id.} (explaining that Medicaid reaches only ten percent of the population and forty percent of the poor).

\(^{27}\) See Chris Middleton, Final U.S. House Vote on Health Care Reform Act (Table), BLOOMBERG, Mar. 22, 2010, http://www.bloomberg.com/apps/news?pid=newsarchive\&sid=afh__O4XRDrw&pos=8 (last visited on Mar. 14, 2011). This site lists the vote of every representative and shows that no Republican voted yes on the bill, 34 Democrats even voted no, and the final count was 219 for and 212 against. \textit{Id.}


\(^{30}\) See generally JACOBS & SKOCPOLO, \textit{supra} note 2, at 111-29 (noting the impetus Senator Scott Brown’s election created among Democrats to broker last minute deals and pass health care reform legislation).
Beyond politics, however, it must be noted that the structure of the Act itself might be expected to evoke resistance. Unlike Medicare, which sought to compensate for the absence of a private health insurance market for the elderly, the Affordable Care Act directly inserts itself into the complex markets of individual and employment-based coverage. For working-age Americans, Medicare was about paying a small amount to plan for the future when illness strikes; by contrast, for individuals who place limited stock in the need to insure against health care costs, the Affordable Care Act is all about obligating individuals into what is rightly perceived to be a considerable investment of resources now, amounting to thousands of dollars annually.

Furthermore, unlike Medicare, the Affordable Care Act depends to an extraordinary degree on a smooth working relationship between state and federal governments at a time when state economies are at an all-time low and political tensions run high after mid-term elections that brought nearly an unprecedented number of freshman Republicans into leadership positions at both the state and federal level. It is the states that regulate the individual and group health insurance markets, and it is the states that will be called upon to assure application of federal reforms to insured plans, even as the federal government maintains primacy over the self-insured market. It is the states that will bear primary responsibility for making Exchanges work for

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31 See Lawrence D. Brown, The Politics of Medicare and Health Reform, Then and Now, 18 HEALTH CARE FIN. REV., 163-68 (1996) (discussing the politics of Medicare in the context of President Clinton's health reform plan). Behind the creation of Medicare was the underlying belief that social justice was needed and that a single-payer system could finance this care without having to manage it too. See id. Hot-button issues, like rising health costs, deficits, and taxes, provided the stimuli for the government to start regulating how care is to be delivered and financed. See id.


Pension obligations, collectively speaking, are estimated to be about $3.5 trillion nationwide, with many states completely incapable of handling their existing debt load. See Sack, supra.

33 See Cooper & Walsh, supra note 32; see also Sack, supra note 32; After 'Shellacking,' Obama Laments Disconnect with Voters, MSNBC (Nov. 3, 2010), http://www.msnbc.msn.com/id/39987514/ns/politics-decision_2010/ (last visited Mar. 14, 2011); Freshman-Heavy, GOP-Led Missouri Legislature Has Work Cut Out, SAINT LOUIS TODAY (Jan. 3, 2011), http://www.stltoday.com/news/local/metro/article_50c583e9-6aad-51be-872e-3f900d4e2ecb.html (last visited Mar. 14, 2011) (reporting that with such a large incoming number of Republicans in the state legislature, there is a clear agenda, though with the number of green GOP legislators who are split amongst themselves on many of the issues, it may not be as easy as it seems).
individuals and small employers and for guaranteeing that adverse selection against Exchanges does not undermine the ability to grow insurance products that meet the needs of workers and their families without access to employer coverage.\(^{34}\) Moreover, it is the states that bear primary responsibility for implementation of Medicaid reforms aimed at providing coverage to the poorest Americans. How this vesting of state responsibilities meshes with a change in the climate of state willingness to be enthusiastic partners in the implementation of reforms in public and private health insurance is a matter that will unfold over the coming years. The federal investment in tax subsidies and Medicaid expansions\(^{35}\) may only partially offset political resistance to a law that redraws the insurance market, fundamentally transforms the largest entitlement program for the poor, and creates new obligations on states to oversee much of the work involved in enrolling millions of new people, assuring industry compliance with a host of benefit design and plan operation rules, and publicly reporting on plan performance.

The source of the tensions lies in the relational leaps embodied in the Act. While the Act represents a major leap forward in the obligations and rights it establishes, in a real sense, the Affordable Care Act is a legislative outgrowth of several decades of reform in various principal sources of U.S. health law. Three federal laws, Medicaid;\(^{36}\) the Public Health Service Act;\(^{37}\) and the Employee Retirement Income Security Act ("ERISA"),\(^{38}\) provide the statutory platform on which the Affordable Care Act was built. Each of these laws has undergone significant changes that in turn helped illuminate the pathway to more advanced health care reform.

For example, during the 1980s and 1990s, Congress undertook a multi-year


\(^{35}\) The Congressional Budget Office estimates that "over the next ten years, the federal government will pay $434 billion of the cost of the Medicaid expansion, while the states will pay roughly $20 billion." January Ageles & Matt Broaddus, *Federal Government Will Pick Up Nearly All Costs of Health Reforms Medicaid Expansion*, CENTER ON BUDGET & POL’Y PRIORITIES (June 18, 2010), http://www.cbpp.org/cms/index.cfm?fa=view&id=3161#_ftnref5 (last visited Mar. 14, 2011).


strategy to expand mandatory Medicaid coverage for all low income children and pregnant women. These reforms were far-reaching in the sense that they laid the groundwork for moving the program away from its cash welfare roots and toward a source of coverage, more broadly speaking, for those excluded by the employer market. While the early reforms were combined into the least costly and most empathetic population groups and triggered broad coalition support, some of the hardest themes that arose in the Affordable Care Act, especially the problems of state resistance to mandates and abortion coverage, made their appearance in these early expansion efforts. At the same time, the relational shifts toward entitlement in all low income children under eighteen, a legislative realignment that took eighteen years to complete, provided at least a conceptual basis for subsequent action on behalf of parents and low income adults without minor children. Indeed, by 2010, nearly half of all states used special demonstration authority or funding through the Children’s Health Insurance Program to extend some level of federally assisted coverage to childless adults.

Similarly, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which followed the 1994 defeat of President Clinton’s health reform plan and the midterm “wave” elections of that year, established a beachhead for federal standards regulating the conduct of private health insurers in both the group and individual markets, as well as of ERISA-governed health benefit plans, insured and self-insured alike. HIPAA’s contribution was its modest, but crucial, introduction of

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40 See id.
federal standards for state-regulated health insurance and the concomitant limits it imposed on state autonomy to set individual and group health insurance standards under the McCarran Ferguson Act. HIPAA served as the policy precursor to the fundamental non-discrimination and fairness reforms of the Affordable Care Act that became possible only with a full restructuring of the health insurance market to reach the underlying risk pool on which the market rests.

Soaring beyond its predecessors, the Affordable Care Act reflects an ambitious and unique legal construct that combines an approach to law in which social contract principles of universality and mutual dependence are linked to a market-based solution to the problem of health insurance. Unlike the original Medicare program, the Act relies on private health insurance markets and employer-sponsored health plans to effectuate coverage; even its considerable expansion of Medicaid is built on the assumption that newly eligible individuals will, like most traditional beneficiaries, be

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Title 7 imposed limitations on group health insurance carriers’ ability to exclude on the basis of pre-existing conditions not falling within specifically enumerated exceptions. See id. § 1181(a)(1). Further, it explicitly prohibited carriers from determining eligibility on the basis of health status. See id. § 1181(a)(3). These early provisions laid the groundwork for the subsequent expansion of federal regulation of insurance carriers that is embodied by the Affordable Care Act. See Colleen Medill, HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?, 65 TENN. L. REV. 485, 496-502 (1998) (offering an overview of the applicable HIPAA regulations).


enrolled in competitive managed care organizations. The Act rests on four structural pillars. The first pillar, the heart of the law, is an individual mandate that requires “applicable” individuals to maintain “minimum essential health coverage” or face

49 Newly eligible Medicare beneficiaries will be entitled to receive “benchmark coverage,” which must be at least equal to “minimum essential coverage” under the Act. See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001(c), 124 Stat. 119., amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 1396u-7(b)). Benchmark benefit packages must provide at least the essential health benefits required under the Affordable Care Act for all qualified health plans sold in the exchanges, as well as health insurance products sold in the nonexchange individual and small group markets. Id. § 2001(c) (to be codified as amended at 1396u-7(b)(5)); see also Medicaid Managed Care: Key Data Trends and Issues, KAISER FAMILY FOUNDATION (Feb. 2010), available at http://www.kff.org/medicaid/upload/8046.pdf (noting that approximately seventy percent of Medicaid beneficiaries received at least a portion of their Medicaid coverage through enrollment in some form of managed care arrangement). Under the Social Security Act, a Medicaid-managed care arrangement can vary significantly in terms of type and structure, ranging from primary care case management to fully integrated managed care organizations. See generally Medicaid Managed Care: Key Data, Trends and Issues, KAISER FAMILY FOUNDATION (Feb. 2010), available at http://www.kff.org/medicaid/upload/8046.pdf. At the bottom, however, Medicaid managed care arrangements generally involve contractual arrangements in which a private contracting entity (a single physician or practice group in a primary care case management model or a larger integrated delivery corporation in the case of a Medicaid managed care organization) assumes some level of financial risk, manages coverage of some or most Medicaid-covered benefits, treatments, and services for a certain defined beneficiary population, and establishes provider network through which beneficiaries receive services. See id. Medicaid managed care is thus similar to membership in a tightly managed HMO where coverage is limited to the receipt of care through a specified provider network. See generally Sara Rosenbaum et al., Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (George Wash. Univ., Dep’t. of Health Pol’y, Working Paper Series 1997). Unlike in traditional HMO structures, however, Medicaid managed care makes exceptions to network controls for family planning services and supplies, as well as for emergency care. See generally 42 U.S.C. § 1396u-2(b)(2). This approach to the organization and financing of health care for Medicaid beneficiaries is expected to carry over in the newly insured population to enable state agencies to contract with private entities that establish provider networks and manage overall care and costs. See Avery Johnson, Insurers Bid for State Medicaid Plans, WALL ST. J., Dec. 29, 2010, http://online.wsj.com/article/SB10001424052748704259704576033943934403286.html (last visited Mar. 14, 2011). A major implementation challenge under the ACA will be to expand the Medicaid managed care market and to align this market with the state health insurance exchange market. See Benjamin D. Sommers & Sara Rosenbaum, Shifting Between Medicaid and Exchange Eligibility Under the Affordable Care Act: Implications for Implementation, 30 HEALTH AFFAIRS 228 (2011). This is because many families at the lower income end of the wage scale experience periodic income fluctuations that will cause them to move between the two sources of purchasing subsidies (i.e., exchange tax credits and direct Medicaid coverage), making continuity of plan enrollment and provider networks highly important. See id.

50 Patient Protection and Affordable Care Act of 2010 § 1501(b) (to be codified as amended at
certain financial penalties. This requirement to secure affordable coverage or face a financial penalty creates the type of robust risk pool on which fundamental health insurance reform can be built. Further, the mandate operates as the *quid pro quo* for both the insurance market reforms and a system of premium and cost sharing subsidies for taxpayers, who purchase a “qualified health plan” through a state health insurance exchange. Subsidies are made available for taxpayers with incomes between 100 and 400 percent of the federal poverty level and who are ineligible for other forms of “minimum essential coverage,” such as employer-sponsored health benefits or Medicaid. Premium subsidies and cost-sharing assistance, targeted at individuals with incomes below 250 percent of the federal poverty level, are financed through advanced tax credits; these tax credits are calculated at the time of enrollment into a qualified health plan through an exchange. Tax credits are based on the prior year’s income and

I.R.C. § 5000A). Exemptions from the penalty imposed upon individuals who do not maintain such coverage are provided for individuals not lawfully present in the U.S. *Id.* § 1501(b) (to be codified as amended at I.R.C. § 5000A(d)(3)). These individuals are also barred from the receipt of advance tax credits, as well as from enrollment in Medicaid, other than for emergency medical care. *Id.* § 1401(a) (to be codified as amended at I.R.C. § 36B(e)(1)). Exemptions are also available on religious grounds, for individuals who are incarcerated, and individuals who are determined not to be able to afford coverage because the monthly premium exceeds eight percent of their household income. *See id.* § 1501(b) (to be codified as amended at I.R.C. §§ 5000A(d)(2), (d)(4), (e)(1)(A)). The penalty system also does not apply to individuals with incomes below the tax filing threshold, members of Native American tribes, persons facing short coverage gaps, and persons determined to have “suffered a hardship with respect to the capability to obtain coverage under a qualified health plan” also are exempt. *Id.* § 1501(b) (to be codified as amended at I.R.C. § 5000A(e)(2)-(5)).

*Id.* § 1501(b) (to be codified as amended at I.R.C. § 5000A(c)). Penalties are set at $695 dollars for an individual and multiple amounts for families ranging up to a maximum three times the individual amount. Patient Protection and Affordable Care Act of 2010 § 1501(b) (to be codified as amended at I.R.C. § 5000A(c)).

*Id.* §§ 1311, 1401.

*Id.* § 1501(b) (to be codified as amended at I.R.C. § 5000A(e)(2)) (describing how the Act exempts individuals with incomes below the tax filing threshold from the individual mandate).


*See* Patient Protection and Affordable Care Act of 2010 § 1311(d) (to be codified as amended
can be recouped for any premium month in which the advance tax credit pay exceeds the amount of credit for which the individual qualifies based on current monthly income.\textsuperscript{57}

The second pillar is comprised of the sweeping and preemptive federal reforms aimed at transforming the insurance and employee health benefit plan market through major restructuring of the Public Health Service Act, ERISA, and the Internal Revenue Code. These reforms, which build upon the more limited non-discrimination standards contained in the 1996 HIPAA legislation,\textsuperscript{58} are aimed at regulating multiple practices by insurers and health plans (with a series of exceptions for “grandfathered health plans”).\textsuperscript{59}

Of primary importance are reforms that halt discrimination against the sick in both the individual and group health markets by explicitly prohibiting the use of pre-existing condition exclusions and discriminatory enrollment practices based on health status, as well as excessive waiting periods before coverage begins in the case of persons with pre-

at 42 U.S.C. § 18031(d)(4)) (describing the minimum functions of an Exchange). For example, section 18031(d)(4)(G) ensures that a calculator is available to determine what the cost of insurance coverage will be after tax credits are applied. \textit{Id.}

\textsuperscript{57} See \textit{id.} § 1401(a) (to be codified as amended at I.R.C. § 36b(f)) (describing how the tax credit will be calculated into a benefit); see also Sara Rosenbaum, \textit{Tax Subsidies for Individuals and Families Who Purchase Coverage Through State Health Insurance Exchanges}, HEALTH REFORM GPS, http://www.healthreformgps.org/resources/tax-subsidies-for-individuals-and-families-who-purchase-coverage-through-state-health-insurance-exchanges/ (last visited Mar. 14, 2011) (discussing how the advance tax credit works).


\textsuperscript{59} Patient Protection and Affordable Care Act of 2010 § 1251 (to be codified as amended at 42 U.S.C. § 18011) (providing grandfather exemption). The Administration’s 2010 regulations establish a series of complex tests for determining whether a plan in the individual or group market can claim grandfathering status; the test focuses chiefly on changes that significantly increase costs to enrollees or diminish coverage. Interim Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538 (June 17, 2010) (to be codified at 29 CFR Part 2590), amended by Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70114 (Nov. 17, 2010) (to be codified at 29 CFR 2590). The list of requirements from which grandfathered plans are exempt can be seen in the June 17th rule. \textit{See generally} Sara Rosenbaum, \textit{Update, Health Reform and Grandfathered Plans}, HEALTH REFORM GPS, http://www.healthreformgps.org/resources/health-insurance-reforms-and-%e2%80%9cgrandfathered-plans%e2%80%9d/ (last visited Mar. 14, 2011).
existing conditions. The market reforms also guarantee the availability and
renewability of insurance, bar rescissions except in the case of misrepresentation and
bad faith, extend dependent coverage to age twenty-six, and require coverage of certain
federally designated preventive services without patient cost sharing. To make
coverage more transparent, the reforms require disclosure of information and the use of
plain language and uniform terms in plan documents, mandate quality reporting, and
alter the pricing of health insurance coverage by establishing federal medical loss ratios
for both individual and group health insurance. To make coverage fairer for people
who have significant health needs that prompt coverage denials, the Act establishes an
external appeals process as a right and revises the internal appeals procedures currently
used by ERISA-governed employee health benefit plans and state regulated insurers.
The Act standardizes and improves coverage through the establishment of a federal
requirement that all health plans in the individual and small group markets, one hundred
full-time employees or fewer, cover certain “essential health benefits,” and the Act
establishes certain patient protections governing access to health care. Finally, the Act

60 See Patient Protection and Affordable Care Act of 2010 § 1201 (to be codified as amended at 42 U.S.C. § 300gg et seq.).
62 See id. § 1001 (to be codified as amended at 42 U.S.C. § 300gg-12) (explaining issuer’s inability to rescind coverage from enrollee unless enrollee engaged in fraud or misrepresentation of material facts).
63 See id. § 1001 (to be codified as amended at 42 U.S.C. § 300gg-14) (extending dependant coverage to twenty-six years of age with permissive inclusion of children of dependants); see also id. § 1001 (to be codified as amended at 42 U.S.C. § 300gg-13(a)) (describing instances that an issuer must not impose any cost sharing requirements).
64 See id. § 10104(f) (to be codified as amended at 42 U.S.C. § 18031(e)(3)(B)) (describing the transparency requirements in disclosures). Specifically, the statute calls for the recipients to be able to readily understand and use the language because it is concise, well-organized, and follows other best practices of plain language writing. Id.
65 See Patient Protection and Affordable Care Act of 2010 § 2717(a) (to be codified as amended at 42 U.S.C. § 300gg-17(a)) (stating requirements for quality reporting that must be implemented within two years of PPACA enactment).
68 State benefit mandates can continue to apply to the non-exchange individual and group markets; state benefit mandates can apply to qualified health plan products sold in state health
establishes coverage for the routine health care costs patients participating in clinical trials incur. Most reforms apply to both the state-regulated individual and group health insurance markets, as well as to the self-insured employer-sponsored health benefit plans, thereby importing the reforms into ERISA.

The third pillar is the establishment of state health insurance exchanges whose purpose is to organize a shopping market for individual and small group health plan products. States can elect to establish their own exchanges or defer to a default federal exchange. States may also consolidate their individual and group health insurance exchanges, operate subsidiary and multi-state regional exchanges, and open their insurance exchanges but only if states pay the incremental premium cost associated with the mandate. See Katherine Jett Hayes, Essential Benefits, HEALTH REFORM GPS (Jan. 12, 2011), http://www.healthreformgps.org/resources/essential-benefits/ (last visited Mar. 14, 2011). To what extent state benefit mandates, which often are mandated treatments and procedures rather than full benefit classes, will be determined to exceed the essential benefit requirement is not yet known. The federal essential benefit requirement consists of eleven separate broad benefit classes: ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Patient Protection and Affordable Care Act of 2010 § 1302(b)(1) (to be codified at 42 U.S.C. § 18022). Thus, for example, it is unclear whether a state benefit mandate requiring coverage of applied behavioral therapy for children with autism would in fact become a required essential health habilitation service benefit in any state with such a mandate.

Most of these provisions are made applicable to ERISA health benefit plans in order to reach the self-insured markets. See Patient Protection and Affordable Care Act of 2010 § 1562(e) (to be codified as codified as amended at 29 U.S.C. § 1185d). An important exception is section 2718 of the Public Health Service Act, which establishes medical loss ratios in the individual and small group insurance markets (80% and 85% respectively). Id. § 10101(f) (to be codified as amended at 42 U.S.C. § 300gg-18); Public Health Service Act § 2718. See Sara Rosenbaum, Health Reform and ERISA, HEALTH REFORM GPS (Sept. 27, 2010), http://www.healthreformgps.org/resources/health-reform-and-erisa/ (last visited Mar. 14, 2011) (explaining market reforms not applicable to ERISA plans that self-insure). See Patient Protection and Affordable Care Act of 2010 § 1311(b) (to be codified as amended at 42 U.S.C. § 18031). Id. § 1321(b)-(c) (to be codified as amended at 42 U.S.C. § 18041) (discussing state election and federal intervention if state fails to elect or state law insufficient under statute).
exchanges to larger employers.\textsuperscript{73} Exchanges may be public or private non-profit entities, and they are obligated to carry out certain functions.\textsuperscript{74} Exchanges are expected to certify and recertify health plans sold as qualified health plans in the individual or small group markets.\textsuperscript{75} They are required to maintain a toll-free assistance hotline as well as an internet website for enrollees, facilitate health plan enrollment, assign quality ratings to health plans, present health plan options in a standardized format, oversee the services of health insurance Navigators, and make available electronic calculators to enable individuals to determine the cost of their plans after applying advance tax credits. Exchanges also bear the responsibility for enrolling eligible individuals in Medicaid and the Children’s Health Insurance Program, certifying individuals who are exempt from the individual mandate, and supporting consumer assistance needs, including linking consumers to grievance and appeals systems. In addition, exchanges are accountable for assisting employers in their use of the small group market.\textsuperscript{76}

The final pillar is a restructuring of Medicaid to extend coverage to all non-elderly low income persons who are legal residents or citizens.\textsuperscript{77} The predominant group to benefit from this change is non-elderly adults historically excluded from Medicaid as a result of their personal characteristics. For instance, these adults have traditionally not qualified for Medicaid due to the absence of minor children in the home as a result of being an older or childless adult. An alternative explanation for exclusion from a state’s Medicaid program is that the adult’s household income, which while below the federal poverty level, nonetheless exceeds the state’s eligibility standard for low income non-pregnant adults.\textsuperscript{78} This reform essentially closes Medicaid’s last

\begin{thebibliography}{99}
\bibitem{note2} Id. § 1311(d)(1) (to be codified as amended at 42 U.S.C. § 18031) (discussing public or private non-profit entities).
\bibitem{note5} Id. § 2001 (to be codified as amended at 42 U.S.C. § 1396a).
\bibitem{note6} \textit{See Medicaid Eligibility Changes}, HEALTH REFORM GPS (Apr. 15, 2010), http://www.healthreformgps.org/resources/medicaid-eligibility-changes/ (last visited Mar. 14,
remaining coverage gap for the poor.

Beyond these four main pillars, the Affordable Care Act makes a multitude of changes in existing laws governing health and health care while establishing a range of new programs and initiatives. Major reforms include changes in Medicare to expand coverage of preventive services and curb excessive and inefficient provider payments. The Act also establishes a National Quality Strategy to improve the quality of health care across all payers, as well as a Prevention and Public Health Fund to broaden community prevention. To address health care access barriers in medically underserved communities, there is a financing provision to expand federally funded community health centers and the National Health Service Corps. Moreover, the law


§ 3022 (to be codified as amended at 42 U.S.C. § 1395jjj) (Medicare shared savings), § 3025 (to be codified as amended at 42 U.S.C. § 1395ww) (hospital readmission reductions program), § 3025 (to be codified as amended at 42 U.S.C. § 1395cc-4) (payment bundling), §§ 3131-37 (to be codified as amended at 42 U.S.C. §§ 1395fff(b), 1395f(j), 1395ww, 1395w-4(c)(2), 1395w-4, 1395m(a)(7)(A), 1395ww) (payment cuts to Home Health Care, Hospice, Medicare Disproportionate Share Hospitals, Mis-valued Codes in Physician Fee Schedule, Equipment Utilization Factor for Advanced Imaging Services, Power-Driven Wheelchairs, and Hospital Wage Index Improvement), § 3201 (to be codified as amended at 42 U.S.C. § 1395w-23(j)) (Medicare Advantage program), § 403 (to be codified as amended at 42 U.S.C. § 1395x(s)(2)) (Medicare wellness visits), §§ 4104-06 (to be codified as amended at 42 U.S.C. §§ 1395x(ddd), 1395m, 1396a(13)) (removing barriers, establishing evidence based coverage, and improving access to preventive services).


tightens federal fraud and abuse laws,\textsuperscript{84} establishes a program of clinical comparative effectiveness research,\textsuperscript{85} and authorizes programs to build the U.S. health workforce.\textsuperscript{86} Finally, the Affordable Care Act makes major revisions in and improvements to American Indian health programs,\textsuperscript{87} and it establishes a new long term care program

\textsuperscript{84} Patient Protection and Affordable Care Act of 2010 § 6402 (to be codified as amended at 42 U.S.C. § 1320a-7k) (adding section 1128J to the Social Security Act). The Affordable Care Act amends the Social Security Act by imposing civil liability not only on those who submit claims, but also upon others involved as well. \textit{Id.} Additionally, the Act clarifies that with regard to the anti-kickback statute, an individual may be liable without actual knowledge or specific intent to commit a violation. \textit{Id.} Finally, the Act increases the federal sentencing guidelines applicable to health care fraud. \textit{Id.; see also Fraud and Abuse: Revisions to the Anti-Kickback Statute, HEALTH REFORM GPS (May 20, 2010), http://www.healthreformgps.org/resources/fraud-and-abuse-revisions-to-anti-kickback-statute (last visited Mar. 14, 2011) (discussing federal changes to the fraud and abuse statute and issues that may arise as the various provisions are enacted).}


\textsuperscript{87} Patient Protection and Affordable Care Act of 2010 §§ 2901-2902 (to be codified as amended at 25 U.S.C. § 1623, 42 U.S.C. § 1395qq). The Affordable Care Acts improves American Indian health care programs by enacting the Indian Health Care Improvement Reauthorization and
known as the Community Living Assistance Services and Supports Act.\textsuperscript{88}

In laying this enormous foundation, the Act alters a series of longstanding relationships that historically have characterized the U.S. health insurance system, some moderately, some quite profoundly: (1) between individuals and health care financing; (2) between employers and their workers; (3) between health insurers and markets; and (4) between the federal and state governments. A fifth set of legal relationships, between health care financing on the one hand and health care itself on the other, remains essentially untouched, although the Affordable Care Act does call for a series of pilot demonstrations aimed at improving health care quality and efficiency under the Medicare program.\textsuperscript{89} The fact that the organization and delivery of health care remains the province of state law and that the federal reforms attempt to nudge change without mandating it is ironic given the lengths to which opponents went to paint the law as an onslaught on health care itself.\textsuperscript{90}

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\textsuperscript{88} Id. §§ 8001-8002 (to be codified as amended at 42 U.S.C. § 201 et seq.). The purpose of the Community Living Assistance Services and Supports Act, ("CLASS Act"), is to "establish a national voluntary insurance program for purchasing community living assistance services and supports." Id.

\textsuperscript{89} See, e.g., id. § 3021 (to be codified as amended at 42 U.S.C. § 300jj-51) (establishing the Center for Medicare and Medicaid Innovation and adding section 1115A to the Social Security Act); id. § 3022 (to be codified as amended at 42 U.S.C. § 1395 et seq.) (creating a Medicare Shared Savings Program through the establishment of Accountable Care Organizations under section 1899 of the Social Security Act). See generally Center for Medicare and Medicaid Innovation, HEALTH REFORM GPS, (May 13, 2010), http://www.healthreformgps.org/resources/center-for-medicare-and-medicaid-innovation (last visited Mar. 14, 2011) (outlining the Center for Medicare and Medicaid's authorization to undertake broad testing of Medicare service delivery and payment structures); Accountable Care Organizations -- Medicare Pilot Program at 1, HEALTH REFORM GPS (Apr. 29, 2010), http://www.healthreformgps.org/resources/accountable-care-organizations-%e2%80%93-medicare-pilot-program (last visited Mar. 14, 2011) (discussing potential use of ACOs to restructure Medicare coverage).

\textsuperscript{90} See, e.g., Jim Rutenberg & Jackie Calmes, False 'Death Panel' Rumor Has Some Familiar Roots, N.Y. TIMES, Aug. 14, 2009, at A1 (discussing false rumor that health care reform would include government-sponsored death panels). Nothing got the press and the blogosphere going during the summer health reform town hall meetings quite like the charge that the health reform legislation would establish death panels to make decisions about health care for seriously ill and dying people. See id. (describing town-hall reactions to health care reform). There was of course no basis to the charge, one of a scrum of charges leveled at the law. See id. (noting no proposal to cut off care to critically ill to cut costs); see also Brooks Jackson, Seven Falsehoods About Health Care, NEWSWEEK, Aug. 14, 2009, http://www.newsweek.com/2009/08/13/seven-falsehoods-about-health-care.html (last visited Mar. 14, 2011) (listing other false charges, including making private insurance illegal, requiring suicide counseling, and providing care for illegal immigrants). The blizzard of accusations of course took their toll over time. See also Health Care Plan: Favor/ Oppose,
A. Individuals and Health Care Financing

Historically, the decision whether to insure oneself or opt for self-insurance in the hope that a way to pay for care will materialize when it is needed has always been an economic option for Americans. Of course, for millions of Americans, the decision to go without coverage is hardly the stuff of choice; rather, it is the result of the high cost of individual coverage, the absence of employer coverage, health conditions that leave millions uninsurable, or a combination of all three. At the same time, health insurance, unlike automobile or homeowners’ coverage, has always been understood as optional, with no requirement that those who use health care be insured. The roots of this state of affairs can be found in a combination of the market and economic barriers to coverage in the absence of work at a job that offers health benefits, Americans’ social and cultural attitudes and beliefs about the role of government in the lives of individuals, and the inevitable responses of a health insurance industry that has evolved without the basic universal risk pool underpinning that is essential to any national insurance system.

All other wealthy industrialized nations have come to grips with this problem, but with the exception of Medicare, the U.S. has remained stubbornly resistant to a compulsory approach to health care financing. Instead, bowing to culture and politics, the nation has allowed a series of structural failures leading to widespread lack of health care insurance.


92 See generally Symposium, The Constitutionality of Mandates to Purchase Health Insurance, 37 J. L. MED & ETHICS 38 (2009) (discussing theories under which mandate to purchase health insurance could be constitutional). In this author’s view, this would neither be a wise nor humane idea, even if a lawful exercise of Congress’ Commerce Clause powers. Indeed, the American health care system, through the imposition of requirements such as the Emergency Medical Treatment and Active Labor Act on all Medicare participating hospitals, the establishment of federally funded community health centers to provide comprehensive primary health care to medically underserved urban and rural communities, and the enactment of Medicaid, has sought to blunt the worst Social Darwinist results of being uninsured. See 42 U.S.C. § 1395dd (2006) (requiring hospitals to screen and treat those with emergency medical conditions); 42 U.S.C. § 254b (2006) (creating health centers for medically underserved populations); 42 U.S.C. § 1396 (2006) (establishing Medicaid).

93 See Timothy S. Jost, Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response 268-79 (Oxford Univ. Press 2003) (discussing the fundamental elements of a national insurance system).
insurance to persist, even in the face of a health care system that is the world’s costliest,\textsuperscript{94} as well as a remarkable body of evidence regarding the direct and spillover economic consequences flowing from having so many millions of uninsured Americans in the national economy.\textsuperscript{95}

The Affordable Care Act reverses this longstanding deference to culture and politics, requiring coverage for those who can afford it in accordance with affordability standards defined under the law.\textsuperscript{96} Because Medicaid, which provides the pathway to coverage for the poorest Americans, is voluntary with states, the law exempts this population and instead, aims its compulsory provisions only at individuals whose household income exceeds the federal tax filing thresholds.\textsuperscript{97} With the exception of those who seek a religious exemption, experience a hardship recognized by the Secretary of Health and Human Services, are incarcerated, or who are Native Americans, the relationship between individuals and the health care system is transformed and moved from an iffy proposition of affordability at the point of service to one of substantial prepayment.\textsuperscript{98}


\textsuperscript{96} Under the Act, coverage is determined to be affordable if premiums do not exceed eight percent of household income. \textit{See supra} note 52; \textit{see also} Rosenbaum, \textit{supra} note 59 (detailing eligibility requirements).

\textsuperscript{97} \textit{See supra} note 52; \textit{see also} Rosenbaum, \textit{supra} note 59 (detailing eligibility requirements).

\textsuperscript{98} \textit{See supra} note 52; \textit{see also} Rosenbaum, \textit{supra} note 59 (detailing eligibility requirements).
B. Employers and Workers

Historically, employers have had the liberty to offer subsidized insurance as part of their employee compensation packages. Many authors have recounted the origins of the voluntary employer-sponsored system. Under federal law, employers are free to contribute or not toward the cost of employee health benefits through the establishment of subsidized health plans. Employer choices tend to track their size and wage levels, and as a result, workers at firms that are smaller and pay lower wages are significantly uninsured.

Beyond the basic choice of whether or not to offer and pay for any insurance

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100 See Standard Oil Co. of Cal. v. Agsalud, 633 F. 2d 760 (9th Cir. 1980); HAWAII INST. FOR PUBLIC AFFAIRS, Prepaid Health Care Act, available at http://www.healthcoveragehawaii.org/pdf/PrepaidHealthCareAct.pdf (discussing Hawaii’s exemption to ERISA). As a result of an amendment to the Employee Retirement Income Security Act (“ERISA”), which enshrines employer choices about employee health benefits, employers in Hawaii must establish and fund employee health benefit plans. See HAWAII INST. FOR PUBLIC AFFAIRS, supra. This requirement was added to ERISA after a federal appeals court struck down Hawaii’s then-existing employer mandate as preempted by the 1974 passage of ERISA. See HAWAII INST. FOR PUBLIC AFFAIRS, supra. Whether a law mandating employers pay a tax to help support the cost of health insurance offered through a public program is, in fact, preempted by ERISA is uncertain. See Harvey D. Cotton & Lesley F. Arnould, Health Care Reform: Yesterday and Tomorrow the Impact of State and Federal Law on Employers, 7 J. HEALTH & BIOMEDICAL L. 91, 95-97 (2011) (reviewing ERISA preemption issues in light of PPACA); see also Golden Gate Rest. Ass’n v. City and County of San Francisco, 512 F.3d 1112 (9th Cir. 2008), denied rev. en banc, 558 F.3d 1000 (9th Cir. 2009), cert. denied, 130 S. Ct. 3497 (2010) (holding ERISA did not preempt a San Francisco employer spending ordinance).

101 More than three quarters of the uninsured live in working families and sixty-one percent live in families with a full-time worker. See KAISER FAMILY FOUNDATION, supra note 91. See generally KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS ANNUAL SURVEY (2010), available at http://ehbs.kff.org/pdf/2010/8085.pdf (illustrating that both offer and premium subsidy rates are significantly lower in smaller and low wage-dominated firms). In low wage firms, defined as firms where thirty-five percent of workers earn twenty-three thousand dollars or less, only forty-eight percent of employers even offer a plan. See id. at 40. Furthermore, in low wage firms, employees have to contribute twenty-four percent of their premiums, compared to an eighteen percent contribution rate in firms with fewer lower wage workers. Id. at 89.
coverage, employers have also enjoyed broad discretion over benefit design and plan administration choices. ERISA-governed health plans, virtually all health benefit plans offered by private employers, have faced few restrictions on their choices. With the notable exception of the Mental Health Parity Act and a handful of other laws that place modest design, content, and plan administration requirements, in certain situations, (e.g., coverage for newborns and mothers continued benefits for certain college students with serious health conditions, and reconstructive surgery for women with breast cancer), ERISA-governed health benefit plans have been free from constraint. If self-insured, ERISA plans have enjoyed almost complete autonomy; if insured, plans have been subject essentially to whatever standards might apply under a state’s group health insurance laws. Furthermore, while ERISA requires that employers provide “full and fair review” procedures for employees who seek to appeal the denial of a claim, ERISA did not provide for external and impartial administrative reviews of denied claims. Instead, participants and beneficiaries whose claims were denied were limited to federal judicial review. Moreover, under ERISA jurisprudential principles, this review was limited as a result of the broad discretion accorded to plan fiduciary decisions.

The Affordable Care Act alters this historic relationship between employers and workers. The Act contains no employer mandate. At the same time, the law imposes a

106 See Metropolitan Life Ins. Co. v Mass., 471 U.S. 724, 747 (1985) (confirming a distinction between self-insured plans, which are free from state regulation because of the “deemer clause,” and insured plans, which are not).
107 Employee Retirement Income Security Act of 1974 § 503, 29 U.S.C. § 1133(2) (2006). A full and fair review requires the plan’s fiduciary to consider all pertinent information reasonably available, with the decision being supported by substantial evidence, and the fiduciary must promptly inform the participant of the decision in writing that is easily understood by a layman, citing the specific reasons with supporting evidence why the claim was denied and providing the participant with an opportunity to examine the evidence, by permitting the participant to make written comments and/or present rebuttal documentary evidence. Hamilton v. Mecca, Inc., 930 F. Supp. 1540, 1551-52 (S.D. Ga., 1996).
108 See Firestone Tire and Rubber v. Bruch, 489 U.S. 101, 115 (1989) (accordine broad deference to the decision of plan fiduciaries where governing ERISA plan documents reserve such discretion to the plan fiduciary). But see Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (permitting courts to set aside the broad discretionary standard where evidence suggests that the decision was influenced by a conflict of interest).
financial assessment on large employers, fifty or more employees, who either do not offer coverage or whose coverage subsidies are deemed too low to make coverage affordable, thereby qualifying their employees for advance premium tax credits. The Affordable Care Act also requires that employers offer a “free choice voucher” to employees with incomes less than 400 percent of the federal poverty level, whose share of the premium exceeds 8 percent but is less than 9.8 percent of their income and who choose to enroll in an Exchange plan. This requirement provides an offset in the case of employees who elect to seek more affordable coverage through health insurance exchanges. In addition, employers with more than two hundred employees are required to automatically enroll employees into employer offered health insurance plans, although employees may opt out.

Beyond the requirement to contribute to coverage, the Act imposes a series of federal coverage and administration standards on employer-sponsored health plans, whether insured or self-insured. By superimposing the Public Health Service Act requirements onto ERISA, the Affordable Care Act effectively requires that ERISA plans adhere to federal standards. The most important changes under the Affordable Care Act that represent a major advance beyond the earlier HIPAA non-discrimination standards are those that address the issues of plan design and administration. These reforms include the use of uniform explanation of benefit documents, an obligation on the part of insurers selling in the individual and small group markets to cover “essential health benefits,” a bar to previously permitted waiting periods longer than ninety days in the case of persons with pre-existing conditions, coverage of federally designated preventive services without cost sharing, routine health care for patients participating in clinical trials, and the introduction of a binding external appeals process. Whether the

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110 Id. § 10108 (to be codified as amended at 42 U.S.C. § 18101).

111 Id. § 1511 (to be codified as amended at 29 U.S.C. § 218A).

112 See id. (laying out PPACA amendments to both the Public Health Service Act and ERISA).

113 Id. § 1201 (to be codified as amended at 42 U.S.C. § 300gg-6).

114 See Patient Protection and Affordable Care Act of 2010 § 1201 (to be codified as amended at 42 U.S.C. § 300gg-15) (explaining rules associated with the utilization of uniform explanations for coverage documents), § 1201 (to be codified as amended at 42 U.S.C. § 300gg-7) (prohibiting excessive waiting periods over ninety days for persons with pre-existing conditions), § 1001 (to be codified as amended at 42 U.S.C. § 300gg-13) (stating health plans must, at a minimum, provide certain preventive health services), § 10103(c) (to be codified as amended at 42 U.S.C. § 300gg-8) (explaining provisions allowing coverage for individuals participating in approved clinical trials), §
addition of a binding external review will alter the deferential standard accorded
decisions of ERISA plan fiduciaries remains to be seen, of course, but the presence of a
binding impartial review system significantly alters the evidentiary landscape against
which the ERISA deference standard has developed.

C. Health Insurers and Markets

In keeping with the absence of a stable risk pool, the federal and state
governments accordingly provided insurers a wide berth in three distinct market
contexts. First, insurers have had latitude in the state-regulated individual health
insurance market, where a dearth of laws historically have allowed insurers wide
discretion to medically underwrite applicants and policy holders, as well as design
benefits and coverage to favor healthy individuals, price sick people out of the market,
and rescind coverage even for simple errors. Second, insurers have enjoyed leeway in
the state-regulated group market, which engaged in slightly more robust regulation
(particularly after the enactment of HIPAA), while at the same time permitting pricing
and exclusionary practices that especially hurt smaller groups. Finally, third party
administered products sold to self-insuring employers have been exempted from state
laws as a result of ERISA preemption principles.

The Affordable Care Act essentially reinvents the relationship between insurers
and these three markets as of January 1, 2014, swapping creation of a more stable risk
pool for the right to take what amounts to a public utility approach to the evolution of
the market for individual and small group products. In this model, a private market
good is deemed so imbued with the public interest that it is vested with a series of social
obligations to assure access, affordability, and fairness. This method is reflected in the
federal standards established for coverage, administration, medical loss ratios, and
product pricing, as well as through the use of governmentally sponsored purchasing

1001 (to be codified as amended at 42 U.S.C. § 300gg-19) (describing the amendments to the
appeals processes). Insured plans must submit to state external review procedures that meet
minimum requirements delineated by the United States Department of Labor on July 23, 2010.
See also 75 Fed. Reg. 43330-43364 (July 23, 2010).

Time?, HEALTH AFFAIRS (Oct. 12, 2002), available at http://content.healthaffairs.org/content/
early/2002/10/23/healthaff.w2.372.

116 Sara Rosenbaum, A Broader Regulatory Scheme: The Constitutionality of Health Reform, 363 NEW.
NEJMp1010850. This article discusses the importance of viewing the private market as
fundamentally transformed into a public good under the Affordable Care Act, that is, a private
enterprise that nonetheless becomes a public accommodation.
arrangements for individuals and small groups resulting from the establishment of state health insurance exchanges.

The Affordable Care Act does not shut down the non-exchange individual and small group markets. Indeed, it expressly preserves the self-insured market, as well as insurers’ right to sell products in the non-exchange market, particularly in the case of larger groups that continue to purchase insurance rather than self-insure.117 Of course much can go awry. Insurers may refuse to sell products in health insurance exchanges, although it is through the exchanges that they will acquire nearly half of the newly insured population, while the remainder will be covered through Medicaid. Insurers could leave the health insurance market altogether, sticking to less regulated products such as life, disability, and homeowners insurance. But health insurance is a lucrative industry, and no one seriously thinks, at least not as of the end of 2010, that large national insurers are going anywhere any time soon. Instead, it is likely that many smaller regional insurers may choose to exit the market, more specifically the individual market, as a result of heavier regulation of product design, the obligation to take all comers, and the imposition of a federal floor for what insurers must spend on medical care activities including both payment of medical claims and quality improvement activities.118 But the consolidation of the insurance industry is undoubtedly an inevitable byproduct of system transformation toward a more cohesive and fairly regulated market for health care financing in which profits must be made from designing coverage products that bring more value to health care rather than by selecting only good risks.119

118 See 75 F.R. §§ 74864-74934 (2010), to be codified at 45 C.F.R. 158 (defining what constitutes medical losses under the Affordable Care Act); see also Troyen A. Brennan & David M. Studdert, How Will Health Insurers Respond to the New Rules Under Health Reform, 29 HEALTH AFFAIRS 1147, 1149 (2010) (indicating that there is seemingly no provision in the health reform bill that prevents insurers from abandoning small markets for less regulated markets such as self-insured).
D. Federal and State Governments

Deferential principles have long controlled the relationship between federal and state governments. Following the landmark decision in *U.S. v. Southeastern Underwriters Ass'n*,¹²⁰ which applied federal antitrust laws to the insurance industry, Congress enacted the McCarran Ferguson Act¹²¹ to clarify the states' primacy where regulation of insurance is concerned. To be sure, ERISA, and to a much lesser extent HIPAA, represented major departures from the principles embodied in the McCarran Ferguson Act. ERISA shields all health plans from major bodies of state law.¹²² At the same time, states retain enormous discretion over the design and performance of health insurance products sold in the individual and group health markets.¹²³

The same can be said for Medicaid, whose statutory structure imposes extensive requirements on participating states. The federal Medicaid law traditionally vests states with significant discretion over who will be covered, what benefits will be provided, what providers will be allowed to participate in the program, how providers will be regulated and paid for their services, and how states' plans will be administered.¹²⁴ The

¹²³ See Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 387 (2002); Metropolitan Life Ins. Co. v. Mass., 471 U.S. 724, 758 (1985) (explaining that various state statutes do not conflict with the ERISA savings clause). While ERISA supersedes state laws relating to employee benefit plans, section 514(b)(2) provides that ERISA shall not relieve any person from laws regulating insurance. See Metropolitan Life Ins., 471 U.S. at 724. In Metropolitan Life Inc., at issue was a Massachusetts statute requiring that certain mental health care benefits be provided to residents insured under a general health insurance policy. See id. The Supreme Court held that the mandated benefit law is one that regulates insurance, and therefore not preempted by ERISA. See id. at 758. Similarly, in Rush Prudential HMO, Inc., the Supreme Court held that a statute requiring HMOs to provide independent review of disputes with a primary care physician, did not conflict with ERISA. See Rush Prudential HMO, Inc., 536 U.S. at 381. Most recently, in Kentucky Ass'n of Health Plans, Inc., the Supreme Court provided that “Any Willing Provider” provisions regulated insurance, and thus, were not preempted by ERISA. See Kentucky Ass'n of Health Plans, Inc., 538 U.S. at 341.
¹²⁴ See generally U.S. CONGRESSIONAL RESEARCH SERVICE, 111TH CONG., MEDICAID: A PRIMER (2010). Medicaid is an entitlement program that finances certain health care services to traditional mandatory groups, such as the elderly, as well as optional groups included by recent changes in the law, such as certain individuals who age out of foster care. See id. States are also given the ability to establish their own payment rates for Medicaid providers. See id. Traditionally, states are allowed to require beneficiaries to share in the cost of Medicaid services;
majority of state Medicaid expenditures are for services considered optional under federal law, and state Medicaid programs vary enormously depending on the underlying health care systems on which they rest.

The Affordable Care Act changes these federal-state dynamics to a considerable degree. In the private health insurance market, the federal presence is much more heavily felt. Although states maintain their primary regulatory function and can maintain both Exchange and non-Exchange markets, the Act fundamentally alters the federal-state relationship by creating a federal framework for the regulation of health insurance. It is hard to imagine that over time the expansion of such a strong federal presence in the state-regulated insurance market will not further alter federal-state relationships, particularly where implementation of federal standards and their interpretation and enforcement are concerned. Numerous federal preemption issues can be expected to arise, as states attempt to reconcile against these federal standards their own regulatory requirements related to benefits and coverage, insurer conduct and practices, and patient protections. The sweeping nature of the federal reforms outlined above, overlaid on a pre-existing and complex state insurance regulatory structure, inevitably can be expected to create tensions.

Of greatest interest may be the federal-state interaction around the establishment of health insurance Exchanges. When implemented, exchanges will be creatures of state law but subject to extensive federal requirements to assure basic comparability in design and function across the states. Furthermore, the federal interest in the long term success of health insurance exchanges is paramount because the federal system of tax credits—and the ultimate cost of these credits—is tied to the fate of health insurance exchanges, so much so that the federal government retains the power to

however, new legislation has provided more alternatives for service cost sharing. See id. The new legislation sets out options for individuals and families with income levels at or below the federal poverty level, including the restriction of premiums and percentage caps on the total amount of cost-sharing they are required to pay, relative to their income. See id.

125 Medicaid, An Overview of Spending on “Mandatory” vs. “Optional” Populations and Services, KAISER FAMILY FOUNDATION, 2-3 (June 2005), available at http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf. Some of the mandatory Medicaid beneficiary groups include children age six and older, below 100% of the federal poverty line (“FPL”); children under age six, below 133% of the FPL; pregnant women at or below 133% of the FPL; and elderly persons with income below 74% of the FPL. Id. Some of the optional Medicaid beneficiary groups include low income children above 100% FPL who are not mandatory by age, pregnant women with greater than 133% FPL, individuals at risk of needing nursing facility, certain working disabled persons, and the medically needy. Id.

operate a federal exchange in a state's borders if the state elects not to do so. This balancing of the need for a reliable market structure for health insurance at the federal level against state powers to design and operate exchanges within federal parameters represents a legislative choice on the part of Congress and the Administration whose effects will be felt for years to come.

The same can be said of Medicaid. Virtually since Medicaid's enactment, the absence of coverage for poor adults has been as noteworthy as the program's many achievements. States could, of course, cover low income adults with their own funds, and for awhile some did. But the cost of health care and states' adherence to the federal financial participation framework ultimately led to the near exclusion of non-pregnant, non-disabled, non-elderly adults from state Medicaid programs. The Affordable Care Act changes this entirely, making Medicaid part of the foundation on which health reform is built, converting the program into a pathway to health insurance for low income persons generally. States are free to opt out of Medicaid, but those that elect to participate will do so under a framework that ends discrimination against the poor.

It is fair to say that the Affordable Care Act takes this alteration of the state health landscape for public and private health insurance to new heights. The actions of Congress were essential to the social landscape against which the health care system operates. The insurance industry on which health care financing rests is too vast, too complex, and too determinative of the nation's overall economic health to have done otherwise. Furthermore, the legislation does so through a vast infusion of federal funds into state economies with hundreds of billions of dollars in new federal spending for tax-subsidized coverage and Medicaid, with only nominal state Medicaid contributions. The health insurance system for the non-elderly in the U.S. will remain

Stat. 1029 (2010) (to be codified as amended at 42 U.S.C. § 18031). Pursuant to the Affordable Care Act, each state will establish an exchange designed to facilitate the purchase of qualified health plans and assist small employers in getting their employees to enroll in the qualified health plans. Id. Tax credits available for individuals and small employers are limited to products sold in health insurance exchanges. Id.

127 See id. § 1321 (to be codified as amended at 42 U.S.C. § 18041). In the event that a state fails to establish an exchange, the Secretary shall establish and operate an exchange within that state. Id. However, there will be no preemption of any state law that does not specifically prevent the application of this title. Id.

128 See supra notes 124-25 (discussing Medicaid).

129 See HEALTH REFORM GPS, supra note 78 (detailing Medicaid eligibility changes); see also KAISER FAMILY FOUNDATION, supra note 78 (comparing pre PPACA law governing Medicaid and the Children's Health Insurance Program with the new reforms).

130 One major study projects that the Affordable Care Act will result in nearly $500 million in new federal Medicaid investments, with a state cost of only slightly more than $20 billion over
embedded in state governance, but the rules of the game are now predominantly federal. Much as is the case with banking, another system that results in a major flow of funds across the nation without regard to state borders, the financial basis for health care, which consumes more than one-sixth of the U.S. economy, is now subject to a comprehensive federal regulatory scheme.

III. Changing Legal Relationships and the Course of Implementation

As of late fall, 2010, it is impossible to conclude whether the Affordable Care Act’s cures to what ails the U.S. health care system will take, or if the Act will unravel as a result of the midterm elections, the acute politicization of the law in advance of the 2012 Presidential election, and a series of judicial challenges to its constitutionality.132 The Act, however, represents an unprecedented effort to combine the tools of market reform with a reimagining of the social contract that binds Americans to each other and to the health care system.

The Affordable Care Act is nothing less than a game changer where the nation’s expectations about health insurance are concerned. Today, Americans understand that they can get health insurance if they work at the right job, are old enough or disabled enough to qualify for Medicare, or are poor enough to qualify for Medicaid (an expectation about which most adults would be wrong). If all goes well, then perhaps a decade from now, having health insurance coverage will be the “new normal” in the national culture. If the Affordable Care Act fails, then the nation’s health care system can be expected to continue to face a steady unraveling, burdened by inexorable cost growth, an increasing proportion of the population without insurance coverage, and tectonic shifts in the very availability of health care itself for urban and rural communities alike laboring under an insufficient paying customer base to support adequate health care.

The Affordable Care Act raises a series of challenges that will become more evident as implementation moves forward. Affordability can be expected to be a central


issue in the enforcement of the individual mandate, since the premiums subsidies are limited in relation to household income and leave Americans with a significant financial exposure to the cost of coverage. Whether minimal subsidies combined with a relatively gentle penalty for being uninsured will create a large cohort of individuals and families who remain uninsured on hardship grounds remains to be seen.

Likewise, it is not clear whether the coverage and pricing reforms envisioned under the law, as well as the establishment of exchanges coupled with rigorous standards for qualified health plans, will create a situation in which insurers will refuse to participate because of a weak insurance pool and high opportunity costs. Similarly, it remains to be seen whether the employment based health insurance system will hold for all but the largest self-insured employers or whether, in doing the financial calculus that goes into employee compensation, employers will instead opt to take advantage of tax subsidized purchasing marts, pay the penalty, and exit. This would hardly be the worst thing in the world from a structural viewpoint, since establishing and maintaining health insurance coverage without the constant fear that access to affordable health care will be undermined by the loss of or change in a job would be a very positive development. But whether American culture is ready to divorce having insurance from having a job also remains to be seen.

Finally, the Affordable Care Act represents a new federal-state partnership, one in which states continue to play a primary role in the regulation of public and private health insurance but with a much stronger federal partner. Federalism is preserved, while at the same time, fundamentally altered through a sizable amount of federal law and a vast cash infusion. The perilous condition of state economies perhaps makes this new chapter in federalism a bit hard to envision, but at the same time, the long term economic impact of federal funding, coupled with the greater standardization of the health insurance market across state lines, can be expected to produce national effects that no series of state interventions alone ever could achieve.

In the end, the question is whether American culture and politics will allow a new normal to take hold. The Affordable Care Act is about so much more than a monstrously complex law and a significant amount of money; in the end, the Act is about changing the society in which we live. The Affordable Care Act, at its heart, is a reminder that if the health care system is to survive and serve us all, then Americans need to start pulling together in a reasonably well organized single direction.