

University of Tennessee College of Law

Legal Scholarship Repository: A Service of the Joel A. Katz Law Library

UTK Law Faculty Publications

Faculty Work

2-2020

Affording Obamacare

Isaac ("Zack") D. Buck

Follow this and additional works at: https://ir.law.utk.edu/utklaw_facpubs



Part of the [Law Commons](#)

Recommended Citation

Buck, Isaac ("Zack") D., "Affording Obamacare" (2020). *UTK Law Faculty Publications*. 39.
https://ir.law.utk.edu/utklaw_facpubs/39

This Article is brought to you for free and open access by the Faculty Work at Legal Scholarship Repository: A Service of the Joel A. Katz Law Library. It has been accepted for inclusion in UTK Law Faculty Publications by an authorized administrator of Legal Scholarship Repository: A Service of the Joel A. Katz Law Library. For more information, please contact eliza.boles@utk.edu.

Articles

Affording Obamacare

ISAAC D. BUCK[†]

As it approaches its tenth birthday, the Patient Protection and Affordable Care Act (ACA) is devolving. Intended to solve problems that had vexed American health care for generations, the ACA built a comprehensive structure by providing more Americans with accessible health insurance, reordering the private insurance market, expanding and reconfiguring Medicaid, and installing rational incentives into America's health care enterprise. Without question, it was the most important piece of health care legislation since the mid-1960s, and it brought about positive change for millions of Americans.

However, over its short lifespan, the ACA has faced persistent practical, popular, and policy-based challenges. It remains politically tenuous, with the law's imperfections fueling an uninterrupted barrage of legal, administrative, and regulatory attacks, which, piece by piece, have weakened its overall effectiveness. Instead of installing a comprehensive system, the ACA opted to protect American patients and beneficiaries from the market's worst effects without any effective means for cost control. Its failure to address the cost of health care has continued to haunt it, making it unclear whether it will fully collapse or whether a mutated version will lumber into the future. Either would be devastating to the future of American health care. This cost challenge is vividly illustrated by the acute pain experienced by those who receive insurance through its newly constructed exchanges, where millions of Americans face rising premiums and deductibles.

Using lessons from behavioral economics, this Article suggests a reimagining and reordering of the private ACA marketplace in an effort to put it on a more stable financial footing. Tools from the field of behavioral economics—relied upon in the federal Medicare program, public health laws, and employee wellness plans—could be deployed to the ACA marketplaces by creating smarter subsidies that financially reward the most cost-conscious insurance companies. This would sharpen the incentive for insurance companies to seek increasing discounts, lowering the price of care. And no matter the future of the ACA, insights posited here must be part of any future reform effort to address the cost of American health care—an indispensable, but consistently neglected policy goal.

[†] Associate Professor, University of Tennessee College of Law; *Juris Doctor*, University of Pennsylvania Law School; *Master of Bioethics*, University of Pennsylvania; *Bachelor of Arts*, Miami University (Ohio). Special thanks are owed to I. Glenn Cohen, Mark Hall, David Wolitz, Michael Higdon, and Teri Baxter for their insights and suggestions, and to the participants and attendees of the Health Law Policy, Biotechnology, and Bioethics Fall Workshop in September of 2018 at Harvard Law School. Any errors or omissions are my own.

TABLE OF CONTENTS

INTRODUCTION	263
I. AMERICA'S HEALTH CARE HANG-UPS	268
A. THE ACA AS AN ENDURING SPLIT DECISION	271
1. <i>The Undeniable Accomplishment of Access</i>	273
2. <i>Cost Expenditure Growth</i>	277
B. THE PRACTICAL IMPACT	282
II. THE MARKET'S STRUCTURAL CONFLICTS OF INTEREST	286
A. COOPERATIVE CORPORATISM	287
B. SYMBIOTIC PRICING	288
C. POLITICAL AND REGULATORY DEGRADATION	292
III. TEN YEARS OF BEHAVIORAL ECONOMICS	293
A. MODERN POLICY "NUDGES" IN HEALTH LAW	294
1. <i>Consumers and Employees: Soft Efforts</i>	295
2. <i>Organizations and Physicians: Value Payments</i>	298
IV. COST-CONSCIOUS MARKET ARCHITECTURE	300
CONCLUSION	305

INTRODUCTION

More than eight years after its passage—on December 14, 2018—U.S. District Court Judge Reed O’Connor declared the entire Patient Protection and Affordable Care Act (ACA) unconstitutional.¹ Legal experts called the decision an “exercise of raw judicial activism,”² and “not how judges are supposed to act.”³ For their part, conservative columnists called it “an assault on the rule of law,”⁴ “deplorable,”⁵ and deserving of reversal.⁶ No matter its legal defensibility—which, going into 2020 seems debatable at best, even after a Fifth Circuit opinion⁷—Judge O’Connor’s opinion thrusts the ACA into yet another disruptive and confusing period of uncertainty.⁸

Texas v. United States is the newest in a long line of judicial, legislative, administrative, and political threats that have faced the ACA since its creation.⁹ There was *National Federation of Independent Business v. Sebelius (NFIB)* in

1. *Texas v. United States*, 340 F. Supp. 3d 579, 619 (N.D. Tex. 2018).

2. Nicholas Bagley, *The Latest ACA Ruling Is Raw Judicial Activism and Impossible to Defend*, WASH. POST (Dec. 15, 2018), https://www.washingtonpost.com/opinions/2018/12/15/latest-aca-ruling-is-raw-judicial-activism-impossible-to-defend/?utm_term=.f78cef28f396 (“The logic of the ruling is as difficult to follow as it is to defend, and it sets the stage for yet another round of high-stakes constitutional litigation over the future of health care in the United States.”).

3. Jonathan H. Adler and Abbe R. Gluck, *What the Lawless Obamacare Ruling Means*, N.Y. TIMES (Dec. 15, 2018), <https://www.nytimes.com/2018/12/15/opinion/obamacare-ruling-unconstitutional-affordable-care-act.html>.

4. Philip Klein, *I Hate Obamacare, but Texas Judge’s Decision on Its Unconstitutionality Is an Assault on the Rule of Law*, WASH. EXAMINER (Dec. 17, 2018, 11:46 AM), <https://www.washingtonexaminer.com/opinion/i-hate-obamacare-but-texas-judges-decision-on-its-unconstitutionality-is-an-assault-on-the-rule-of-law>.

5. *See Obamacare Needs an Out-of-Court Settlement*, NAT’L REV. (Dec. 17, 2018, 6:30 AM), <https://www.nationalreview.com/2018/12/obamacare-republicans-cant-rely-on-courts-on-health-care/>.

6. *Id.*

7. *See Vann R. Newkirk II, What Happens to Obamacare Now*, ATLANTIC (Dec. 17, 2018), <https://www.theatlantic.com/politics/archive/2018/12/obamacare-remains-despite-judges-ruling-texas/578356/> (“[the] decision rests on three fundamentally controversial and perhaps tenuous interpretations of the law that may be rejected.”); *Will the Supreme Court Save Obamacare Again?*, N.Y. TIMES (Dec. 28, 2018), <https://www.nytimes.com/2018/12/28/opinion/trump-obamacare-supreme-court.html?action=click&module=Opinion&pgtype=Homepage>. The Fifth Circuit issued its opinion on December 18, 2019, striking down the individual mandate, but returning the case to Judge O’Connor to examine severability. *See Abby Goodnough, Obamacare Insurance Mandate Is Struck Down by Federal Appeals Court*, N.Y. TIMES (Dec. 18, 2019), <https://www.nytimes.com/2019/12/18/health/obamacare-mandate.html>.

8. *See Jenny Deam, ACA Still Law of the Land but Consumers Confused and Worried After Judge’s Ruling*, HOUS. CHRON., <https://www.houstonchronicle.com/news/houston-texas/houston/article/ACA-still-law-of-the-land-but-consumers-confused-13469518.php> (last updated Apr. 2, 2019, 1:02 PM); Tucker Higgins and Berkeley Lovelace Jr., *States Demand Clarity on Obamacare Ruling Before Friday to Avoid “Chaos,” and Cite Potential Government Shutdown*, CNBC, <https://www.cnbc.com/2018/12/18/states-demand-clarity-on-obamacare-ruling-before-friday-to-avoid-chaos.html> (last updated Dec. 18, 2018, 1:37 PM).

9. *See Katie Keith, Judge Hears Oral Arguments in Texas v. United States*, HEALTH AFF. BLOG (Sept. 10, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180910.861789/full/>.

2012,¹⁰ *King v. Burwell* in 2015,¹¹ the American Health Care Act of 2017,¹² and as many as seventy other total attempts by Congressional Republicans to “repeal, modify[,] or otherwise curb” it.¹³ These attempts include, of course, the most serious legislative threat in the summer of 2017, neutralized only by an emphatic thumbs-down from ailing Senator John McCain in the middle of the night.¹⁴ The unlikely identities of the law’s rescuers—Chief Justice John Roberts and Senator McCain—have only added to its broader existential drama.¹⁵

And this is not just a story about resistance; some of the punches have landed.¹⁶ There was, most consequentially, the repeal of the individual mandate penalty in late 2017.¹⁷ There have been administrative changes—approaching

10. Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (*NFIB*). While upholding the individual mandate as a tax, *NFIB* made the Medicaid expansion provisions in the ACA voluntary. *Id.* at 569, 646.

11. *King v. Burwell*, 135 S. Ct. 2480 (2015). In *King*, the Supreme Court upheld the ACA against an attack based on statutory analysis, upholding the universal availability of tax credits to all markets. *Id.* at 2495–96.

12. H.R. 1628, 115th Cong. (2017) (enacted). The American Health Care Act sought to peel back protections in the ACA and cut Medicaid funding. *See id.*

13. *See* Chris Riotta, *GOP Aims to Kill Obamacare Yet Again After Failing 70 Times*, NEWSWEEK (July 29, 2017, 6:53 PM), <https://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832>.

14. *See* Jordan Weissmann, *John McCain’s Complicated, Inscrutable Legacy on Obamacare*, SLATE (Aug. 26, 2018, 8:05 PM), <https://slate.com/business/2018/08/john-mccains-health-care-legacy-did-he-really-save-obamacare.html> (“McCain . . . helped rescue the Affordable Care Act twice during 2017.”); *see also* Lauren Fox, *John McCain’s Maverick Moment*, CNN, <https://www.cnn.com/2017/07/28/politics/john-mccain-maverick-health-care/index.html> (last updated July 28, 2017, 3:45 PM); Carl Hulse, *McCain Provides a Dramatic Finale on Health Care: Thumb Down*, N.Y. TIMES (July 28, 2017), <https://www.nytimes.com/2017/07/28/us/john-mccains-real-return.html>.

15. *See Burwell*, 135 S. Ct. at 2507 (Scalia, J., dissenting) (“We should start calling this law SCOTUScare.”).

16. For example, elimination of the individual mandate will cost the system—and American beneficiaries within that system—more, as admitted by the former Health and Human Services Secretary Tom Price, one of the acerbic critics of the ACA, in a jaw-dropping statement in the spring of 2018. *See* Audrey Carlsen & Haeyoun Park, *The Same Agency That Runs Obamacare Is Using Taxpayer Money to Undermine It*, N.Y. TIMES (Sept. 4, 2017), <https://www.nytimes.com/interactive/2017/09/04/us/hhs-anti-obamacare-campaign.html> (“Since being sworn in as health secretary on February 10, Tom Price has posted on Twitter 48 infographics advocating against Obamacare, all of which bear the health department’s logo. . . . Once, Mr. Price tweeted five infographics in a single day.”); Eliza Collins, *Former HHS Sec. Price: Repealing the Individual Mandate “Will Harm” People Insured Through Obamacare*, USA TODAY (May 1, 2018, 11:21 AM), <https://www.usatoday.com/story/news/politics/onpolitics/2018/05/01/former-hhs-sec-price-repealing-individual-mandate-harm/568281002/> (“There are many, and I’m one of them, who believes . . . you’ll likely have individuals who are younger and healthier not participating in that market, and consequently, that drives up the cost for other folks within that market,” Price said during the World Health Care Congress in Washington, D.C., according to *The Washington Times*.”); Margaret Hartmann, *Trump Shows Commitment to Destroying Obamacare by Picking Tom Price for HHS*, N.Y. MAG. (Nov. 29, 2016), <http://nymag.com/daily/intelligencer/2016/11/trump-tom-price-obamacare-hhs.html> (“In a speech at CPAC shortly before the ACA was signed into law, Price said conservatives needed to ‘take our country back’ from ‘a vile liberal agenda that is threatening everything we hold dear as Americans.’”).

17. *See* Robert Pear et al., *Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again*, N.Y. TIMES (Oct. 12, 2017), https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-insurance.html?_r=0 (“Without the subsidies, insurance markets could quickly unravel.”); Margot Sanger-Katz, *Requiem for the Individual Mandate*, N.Y. TIMES (Dec. 21, 2017), <https://www.nytimes.com/2017/12/21/upshot/individual-health-insurance-mandate-end-impact.html>.

what can be called a “synthetic repeal,”¹⁸ which include a shortening of the open enrollment period,¹⁹ a cutting of funding for navigators,²⁰ and the ending of cost-sharing reduction (CSR) payments.²¹ There have also been other softer-but-potent hostilities to the law—including the public relations assault from the nation’s chief executive.²² His comments have led to a majority of Americans holding the belief that the law’s marketplaces are, in fact, collapsing.²³ By early 2019, other threats waited like coiled springs.²⁴

But, as these hazards have mounted, a resilient optimism has enveloped the ACA.²⁵ The ACA is reportedly stabilizing.²⁶ For the first time in its tepid history,²⁷ public approval of the law has exceeded disapproval for more than one

18. Michael Hiltzik, *Trump Plots Another Backdoor Effort to Gut Obamacare’s Consumer Protections*, L.A. TIMES (Oct. 9, 2017, 10:30 AM), <http://www.latimes.com/business/hiltzik/la-fi-hiltzik-trump-associations-obamacare-20171009-story.html>.

19. See Philip Bump, *Here’s How the Trump Administration Is Hurting Enrollment in Obamacare*, WASH. POST (Sept. 28, 2017), <https://www.washingtonpost.com/news/politics/wp/2017/09/28/heres-how-the-trump-administration-is-hurting-enrollment-in-obamacare/>.

20. See Ken Alltucker, *Trump Administration Slashes Funding for Obamacare Outreach Program*, USA TODAY (July 10, 2018, 9:33 PM), <https://www.usatoday.com/story/news/nation/2018/07/10/obamacare-cuts-mean-groups-have-less-sign-up-customers/773728002/>.

21. The decision by the Trump administration to end the CSR payments will save the federal government \$10 billion, but will cost it an additional \$12.3 billion in increased premium-assistance tax credits in 2018. See Rabah Kamal et al., *How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums*, KAISER FAM. FOUND. (Oct. 27, 2017), <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>; Larry Levitt et al., *The Effects of Ending the Affordable Care Act’s Cost-Sharing Reduction Payments*, KAISER FAM. FOUND. (Apr. 25, 2017), <https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>.

22. See Thomas Kaplan, *“Let Obamacare Fail,” Trump Says as G.O.P. Health Bill Collapses*, N.Y. TIMES (July 18, 2017), <https://www.nytimes.com/2017/07/18/us/politics/republicans-obamacare-repeal-now-replace-later.html> (noting that President “declared that his plan was now to ‘let Obamacare fail.’”).

23. See Rachel Bluth, *Americans Have Mixed Feelings About the ACA’s Future—But Like Their Plans*, KAISER HEALTH NEWS (Apr. 3, 2018), <https://khn.org/news/americans-have-mixed-feelings-about-the-aca-future-but-like-their-plans/> (“[O]nly about one-fifth of people who obtain coverage on the individual market were even aware that the mandate penalty had been repealed as of 2019, according to the poll.”).

24. See Amy Goldstein, *New Insurance Guidelines Would Undermine Rules of the Affordable Care Act*, WASH. POST (Nov. 29, 2018), https://www.washingtonpost.com/national/health-science/new-insurance-guidelines-would-undermine-rules-of-the-affordable-care-act/2018/11/29/ff467f46-f357-11e8-aece-b85fd44449f5_story.html?utm_term=.c35db2a36328 (noting that under a new proposal, “states should be free to redefine the use of those [premium-assistance tax credit] subsidies” and “could allow the subsidies to be used for health plans the administration has been promoting outside the ACA marketplaces.”).

25. See Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2018).

26. Sarah Jones, *Obamacare Is Still Going Strong, Despite Trump’s Sabotage Campaign*, N.Y. MAG. (Nov. 28, 2018), <http://nymag.com/intelligencer/2018/11/obamacare-is-still-going-strong-despite-trumps-sabotage.html>.

27. *Kaiser Health Tracking Poll: The Public’s Views on the ACA*, KAISER FAM. FOUND. (Nov. 20, 2019), <https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable—Unfavorable&aRange=all> (showing support for the ACA exceeding 50% for the first time in June of 2017).

year,²⁸ reaching record-high approval in the mid-fifties in early 2018.²⁹ Medicaid expansion has reached thirty-six states and Washington D.C.³⁰ Ezekiel Emanuel says that the ACA's exchanges are "thriving,"³¹ and Sarah Kliff notes that they "are having a surprisingly good year."³² This optimism is reflected at the ballot-box: indeed, the ACA was a winning political issue in the U.S. midterm elections in 2018.³³ And, in the midst of a chaotic attack on its internal gears, federal-based ACA signups slid only four percent during the most recent open enrollment period—sinking slightly from 8.8 million in 2018, to 8.5 million in 2019.³⁴

While the battle between demise and survival may make for captivating media narratives, the story of the ACA in 2019 is nuanced. The political spectacle has obscured the law's internal weaknesses that put its long-term sustainability at risk. Nowhere are the ACA's weaknesses more destructive than in its so-called marketplaces, the platforms where Americans purchase health insurance, and where the law is locked in a permanent state of instability due to a stilted policy design.³⁵ As a result, the ACA has become unaffordable.

On that marketplace, the ACA's priority—of expanding access to health insurance—is made possible by a mix of government payments and government penalties, private ingenuity and state-based regulation. In simplest terms, under the ACA, the federal government has been working to constantly shield Americans from the true cost of their health care, but its financial protection has not proven universal, and certainly not infinitely durable. As a result, too many

28. See Jim Norman, *Affordable Care Act Gains Majority Approval for First Time*, GALLUP (Apr. 4, 2017), https://news.gallup.com/poll/207671/affordable-care-act-gains-majority-approval-first-time.aspx?g_source=link_news9&g_campaign=item_222734&g_medium=copy.

29. *Id.* (according to Gallup, approval bounced between 37% and 48% between early 2013 and late 2016; in April 2017, 55% supported the law); see also Alice Ollstein, *Public Approval of Obamacare Hits Record High Ahead of 2018 Midterms*, TALKING POINTS MEMO (Mar. 1, 2018), <https://talkingpointsmemo.com/dc/public-approval-of-obamacare-hits-record-high-ahead-of-2018-midterms>.

30. See David K. Jones, *The Medicaid Wave*, HEALTH AFF. BLOG (Nov. 8, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181108.484046/full/>.

31. Ezekiel Emanuel, *The Big Secret About the Affordable Care Act: It's Working Just Fine*, WASH. POST (Oct. 31, 2018), https://www.washingtonpost.com/opinions/the-big-secret-about-the-affordable-care-act-its-working-just-fine/2018/10/31/068da248-dd41-11e8-85df-7a6b4d25cfbb_story.html?utm_term=.893b303bafb5.

32. Sarah Kliff, *Obamacare Is Having a Surprisingly Good Year*, VOX (Nov. 26, 2018, 4:35 PM), <https://www.vox.com/policy-and-politics/2018/11/26/18113313/obamacare-mandate-tax>.

33. See Sarah Jones, *How Obamacare Became a Winning Issue*, NEW REPUBLIC (Oct. 16, 2018), <https://newrepublic.com/article/151633/obamacare-became-winning-issue>.

34. See Dan Diamond, *Facing Oversight, Trump's ACA Defense Strategy Is Taking Shape*, POLITICO (Dec. 20, 2018, 10:00 AM), <https://www.politico.com/newsletters/politico-pulse/2018/12/20/facing-oversight-trumps-aca-defense-strategy-is-taking-shape-462043?tab=most-read>.

35. Most recently now, twenty states have filed a lawsuit to declare the ACA unconstitutional following the repeal of the individual mandate. See Erica Teichert, *20 States Sue Federal Government to Abolish Obamacare*, MOD. HEALTHCARE (Feb. 26, 2018, 12:00 AM), <http://www.modernhealthcare.com/article/20180226/NEWS/180229931> ("The U.S. Supreme Court upheld the ACA in 2012, determining President Barack Obama's healthcare reform law was a tax penalty. But the tax cuts signed by President Donald Trump in December zeroed out the penalty, and the rest of the ACA can't stand as law without it, according to the states.").

Americans—particularly those who receive no tax subsidies from the government—remain “unquestionably worse off” under the ACA.³⁶

By seeking to insulate individuals from the cost of their health insurance, the ACA abdicated any effort to actually bring down the cost of health care—to actually set prices for MRIs, for example. The government has sought to provide relief to individuals *without* addressing the *prices* of health care. It failed to spend as much regulatory energy on the cost of the \$629 Band-Aid as it did on subsidies to purchase insurance, for example.³⁷ But without more creative architecture in these private marketplaces, health care expenditures will continue to grow faster than Americans’ paychecks. Coupled with a president hostile to its survival, the ACA’s shields are primed to crack for more and more citizens.³⁸

Health *care* that is too expensive leads to health *insurance* that is too expensive.³⁹ Like a boat taking on water, without a coordinated effort to address the cost challenge of American health care, the ACA’s glittery access gains seem precariously wobbly in 2019.⁴⁰ Using the ACA’s markets—not just to guarantee shaky health insurance access, but as a cost containment mechanism—remains an underdeveloped option, both in the literature and in practice. To secure its survival, the ACA must make private insurance companies prioritize cost control through new incentives learned from behavioral economics.

This Article sets forth a new frame for conceiving of cost control on the private market, pushing to bring ideas from behavioral economics and value-based purchasing onto the ACA’s individual exchange marketplace. Mirroring other areas of modern health law and policy, the subsidy and compensation structure on the ACA marketplace could be organized to incorporate shared savings tools, redirecting incentives so that insurance companies that negotiate

36. See Julie Rovner, *Steep Premiums Challenge People Who Buy Health Insurance Without Subsidies*, NPR (Oct. 7, 2017, 7:00 AM), <https://www.npr.org/sections/health-shots/2017/10/07/555957419/steep-premiums-challenge-people-who-buy-health-insurance-without-subsidies>.

37. See Sarah Kliff, *The Case of the \$629 Band-Aid—And What It Reveals About American Health Care*, VOX (May 13, 2016, 8:10 AM), <https://www.vox.com/2016/5/13/11606760/emergency-facility-fees-american-health-care>.

38. See, e.g., Helaine Olen, *Even the Insured Often Can’t Afford Their Medical Bills*, ATLANTIC (June 18, 2017), <https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/> (“Another study, this one published in *JAMA Oncology*, found the price of one month of an oral-cancer medication increased from \$1,869 in 2000 to \$11,325 in 2014. As insurance companies, desperate to clamp down on their own expenses, cut reimbursements for the more expensive drugs, and employers, hoping to cut their own costs, push employees into high-deductible health-insurance plans, more of this cost ends up being picked up by the patients.”).

39. See Jay Hancock and Shefali Luthra, *High Deductibles Are Forcing Employees to Pay More Money Out of Pocket*, TIME (Sept. 15, 2016), <http://time.com/money/4494938/high-deductible-health-plans-employee-costs/> (noting that, regarding employer-based insurance, “[s]ince 2011, the average deductible for single coverage has soared 63 percent . . . while workers’ earnings have gone up by only 11 percent.”). “Single coverage” premiums raised 19% during that same period from 2011 to 2016. See *id.*; see also Olen, *supra* note 38. Abby Goodnough, *As Some Got Free Health Care, Gwen Got Squeezed: An Obamacare Dilemma*, N.Y. TIMES (Feb. 19, 2018), <https://www.nytimes.com/2018/02/19/health/obamacare-premiums-medicare.html>.

40. The insurance rate already likely reached a high-water mark, with the number of insured Americans likely to drop throughout 2019. See Tami Luhby, *9 Million Fewer Americans Expected to Have Health Insurance in 2019*, CNN (Feb. 26, 2018, 7:47 AM), <http://money.cnn.com/2018/02/26/news/economy/obamacare-trump-insurance/index.html>.

the deepest discounts would be rewarded by the most substantial government subsidies. This shift would seek to address the nagging problem of the price of health care, and, in contradistinction from other policy solutions, would act on the *insurers* and not the *insureds* on the market, seeking to stabilize either the ACA or whatever comes next.

This Article will make these arguments in four parts. In Part I, the current state of the ACA will be documented. In Part II, enduring conflicts of interest baked into the ACA's marketplace will be highlighted. In Part III, the field of behavioral economics, both its doctrinal development and utility in other parts of health law and policy, will be sketched. Finally, in Part IV, a new shared savings for insurance companies on the ACA marketplace will be proposed.

I. AMERICA'S HEALTH CARE HANG-UPS

America's health policy scaffolding reflects a delicate balance between universality and exclusivity, laws and markets, resulting in fragmented implementation and political volatility.⁴¹ Health care in the country is both an open public emergency room and the ruthless private insurance marketplace. America wants both universal and conditional health insurance coverage.⁴² It provides generous health care access to sixty-five-year-olds, but charges sixty-four-year-olds \$21,000 for a diagnosis of indigestion.⁴³ It provides coverage for those living in poverty, but some states—inexplicably—impose premiums on them.⁴⁴ It still does not provide health insurance for all, but requires hospitals to

41. Support for the Affordable Care Act has swung over the last eight years—from a low of 33% support in November 2013, to a high of 52% in August of 2017. See Ashley Kirzinger et al., *Kaiser Health Tracking Poll—August 2017: The Politics of ACA Repeal and Replace Efforts*, KAISER FAM. FOUND. fig.7 (Aug. 11, 2017), <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-august-2017-the-politics-of-aca-repeal-and-replace-efforts/>. Another poll had approval reaching 55% by early 2017. See Norman, *supra* note 28.

42. See Jonathan Easley, *Poll: Majority Supports Single-Payer Health Care*, HILL (Sept. 22, 2017, 1:39 PM), <http://thehill.com/policy/healthcare/351928-poll-majority-supports-single-payer-healthcare>. See Nicholas Bagley and Eli Savit, *Michigan's Discriminatory Work Requirements*, N.Y. TIMES (May 8, 2018), <https://www.nytimes.com/2018/05/08/opinion/michigan-medicaid-work-requirement.html> (“Those in predominantly white rural counties with high unemployment are exempt from the work requirements. Those in predominantly black cities with high unemployment are not.”); see also Aaron Blake, *Medicaid Work Requirements Are One of the Least Politically Controversial Things Trump Has Done*, WASH. POST (Jan. 11, 2018), https://www.washingtonpost.com/news/the-fix/wp/2018/01/11/medicaid-work-requirements-are-one-of-the-least-politically-controversial-things-trump-has-done/?utm_term=.1eaba7b1d067.

43. See Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME MAG. (Apr. 4, 2013), <https://time.com/198/bitter-pill-why-medical-bills-are-killing-us/> (“The bad news was the bill: \$995 for the ambulance ride, \$3,000 for the doctors and \$17,000 for the hospital—in sum, \$21,000 for a false alarm. . . . Because she was 64, not 65, Janice S. was not on Medicare. . . . It turns out that Medicare would have paid Stamford \$13.94 for each troponin test rather than the \$199.50 Janice S. was charged.”).

44. See MaryBeth Musumeci et al., *Approved Changes in Indiana's Section 1115 Medicaid Waiver Extension*, KAISER FAM. FOUND. (Feb. 9, 2018), <https://www.kff.org/medicaid/issue-brief/approved-changes-in-indianas-section-1115-medicaid-waiver-extension/> (“Monthly premiums apply to all beneficiaries from 0-138% FPL based on income and are at least \$1.00.”). Premiums are “tiered,” in that individuals making less than 22% of FPL (income ranges from \$0 to \$223 per month) are charged \$1.00 per month, whereas individuals making between 23% and 50% of FPL (income ranges from \$223 to \$506 per month) are charged \$5.00 per month. *Id.*

treat all, without regard to ability to pay, in an emergency.⁴⁵ Impoverished citizens receive health insurance through the state's Medicaid program—assuming they are impoverished—but only for those belonging to one of the fortified categories making up the “deserving poor.”⁴⁶

A complex regulatory structure results because “we are trying to use markets to distribute something that, at the end of the day, we don't want distributed according to market forces.”⁴⁷ Indeed, health care in America is a human right,⁴⁸ a moral cause,⁴⁹ a foundation for human flourishing,⁵⁰ and it is a consumer good,⁵¹ a risk pool,⁵² and a deductible.⁵³ In this view, American health policy becomes a battle not over how to cure the market, but over when to appropriately empower and when to properly avoid it.⁵⁴ The history of health care policy in America, then, is punctuated by a mix of market-based and market-eschewing solutions.

In the ultimate transformative opportunity in 2010, America cemented long-term shortcomings in the individual marketplace.⁵⁵ The ACA *both*

45. See CTRS. FOR MEDICARE AND MEDICAID SERVS., EMERGENCY MEDICAL TREATMENT ACT AND LABOR ACT (EMTALA), <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index> (last updated Mar. 26, 2012).

46. See Annie Lowrey, *The People Left Behind When Only the “Deserving” Poor Get Help*, ATLANTIC, (May 25, 2017), <https://www.theatlantic.com/business/archive/2017/05/the-people-who-are-left-behind-when-only-the-deserving-poor-get-help/528018/>. Medicaid has limited its coverage to discrete groups throughout its history. *Id.*

47. James Kwak, *The Problem with Obamacare*, BASELINE SCENARIO (May 9, 2016), <https://baselinescenario.com/2016/05/09/the-problem-with-obamacare/>.

48. See Matt Taibbi, *Finally Everyone Agrees: Health Care Is a Human Right*, ROLLING STONE (June 30, 2017, 5:14 PM), <https://www.rollingstone.com/politics/news/taibbi-finally-everyone-agrees-health-care-is-a-human-right-w490605>.

49. See Jack Craver, *Most Americans View Health Care as a Moral Issue*, BENEFITSPRO (Sept. 9, 2015, 11:54 AM), <http://www.benefitspro.com/2015/09/09/most-americans-view-health-care-as-moral-issue/>; see also Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 672 (2003) (“Moral fairness . . . would forbid abandonment of the sick and disabled.”).

50. See Atul Gawande, *Is Health Care a Right?*, NEW YORKER (Sept. 25 2017), <https://www.newyorker.com/magazine/2017/10/02/is-health-care-a-right> (“[The ACA] sever[s] care from our foundational agreement that, when it comes to the most basic needs and burdens of life and liberty, all lives have equal worth.”).

51. See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 7 (1999) (“Opponents of regulation . . . typically argue that the free market will more efficiently allocate resources among health care and other consumer goods than will government mandates.”). *But see* Lawrence Singer, *Health Care Is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It*, 48 LOY. U. CHI. L.J. 703, 703 (2017) (“Many believe that health care is, or should be treated as, a ‘typical’ economic good.”).

52. *What Are “High-Risk Pools” and Do They Lower Health Care Costs?*, NPR (May 6, 2017, 7:48 AM), <https://www.npr.org/2017/05/06/527140030/what-are-high-risk-pools-and-do-they-lower-health-care-costs>.

53. See Russell Korobkin, *Health-Care Costs and the “Moral Hazard” Problem*, WASH. POST (Mar. 10, 2014), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/03/10/health-care-costs-and-the-moral-hazard-problem/?utm_term=.88c212bf2380.

54. See Kwak, *supra* note 47 (“The dirty not-so-secret of Obamacare, however, is that sometimes the things we don't like about market outcomes aren't market failures—they are exactly what markets are supposed to do.”).

55. See Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1705 (2018) (“Despite being a major federal intervention in health policy, the ACA perpetuated and

extended (closer to) universal access to its citizenry *and* stimulated a new private insurance marketplace, carefully contorting itself to harm the market as little as possible. The ACA tightened the regulatory screws against insurance companies but awarded them millions more customers and revenue.⁵⁶ It outlawed the exclusion of individuals with preexisting conditions but allowed insurers to price insurance by zip code, ultimately doing little to bring down the global cost of health care.⁵⁷ The law incentivizes insurance companies' participation—in both individual and private employer marketplaces⁵⁸—by heavily subsidizing them with public funds.⁵⁹ It genetically engineers an artificial market by propping up *both* buyers and sellers.⁶⁰

But this is nothing new. America's conflictual health policy development has followed a simple pattern: legislative solutions that have nobly but languidly expanded access, have been short on devising solutions designed to contain the costs of—or, more directly, pay for⁶¹—those gains in access. No example of America's health care contradiction is more apt than the conspicuously named Affordable Care Act,⁶² a law that guarantees access to millions more Americans, but does little to make the cost of health care any more affordable for the

entrenched the fragmentation of U.S. health care by expanding the various and very differently structured healthcare programs already in existence.”).

56. See Sam Baker, *How the Authors of Obamacare Protected Insurance Companies*, ATLANTIC (Nov. 10, 2013), <https://www.theatlantic.com/politics/archive/2013/11/how-the-authors-of-obamacare-protected-insurance-companies/440853/>; Bertha Coombs, *As Obamacare Twists in Political Winds, Top Insurers Made \$6 Billion (Not that There Is Anything Wrong with That)*, CNBC, <https://www.cnbc.com/2017/08/05/top-health-insurers-profit-surge-29-percent-to-6-billion-dollars.html> (last updated Aug. 6, 2017, 10:16 AM).

57. See *Kaiser Calculator Now Gives Consumers 2015 Zip Code-Specific Premium and Tax Credit Estimates for Marketplace Coverage*, KAISER FAM. FOUND. (Nov. 13, 2014), <https://www.kff.org/health-reform/press-release/kaiser-calculator-now-gives-consumers-2015-zip-code-specific-premium-and-tax-credit-estimates-for-marketplace-coverage/>.

58. See, e.g., Kate Zernike, *The Hidden Subsidy that Helps Pay for Health Insurance*, N.Y. TIMES (July 7, 2017), <https://www.nytimes.com/2017/07/07/health/health-insurance-tax-deduction.html> (“[Tax breaks for employer-sponsored insurance] costs the federal government \$250 billion in lost tax revenue every year . . . [and] economists on the left and the right argue that to really rein in health costs, Congress should scale back or eliminate the tax exclusion on what employers pay toward employees' health insurance premiums.”); see also *Health Insurance Marketplace Calculator*, KAISER FAM. FOUND. (Nov. 1, 2018), <https://www.kff.org/interactive/subsidy-calculator/>.

59. Zernike, *supra* note 58; see also BERNADETTE FERNANDEZ, HEALTH INSURANCE PREMIUM TAX CREDITS AND COST-SHARING SUBSIDIES: IN BRIEF, CONG. RESEARCH SERV. 9 (2017), <https://fas.org/sgp/crs/misc/R44425.pdf> (“For tax year 2014, approximately 3.4 million tax returns indicated receipt of advance payments of the ACA tax credit, totaling to almost \$12 billion.”).

60. Indeed, this market is dependent upon a committed, supportive government to work. The Trump Administration has shown how important this is to the functioning of the ACA's individual exchange marketplaces.

61. See, e.g., William P. Gunnar, *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 ANNALS HEALTH L. 151, 173 (2006) (noting that “EMTALA represents an unfunded mandate”); Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 702 (2006) (“Thus, EMTALA's ‘unfunded mandate’ becomes a target for providers' ire in an increasingly pinched system.”).

62. “One of the ACA's key failings is that, despite its name, it does far too little to make coverage truly affordable for many economically squeezed Americans.” Josh Mound, *How to Win Medicare for All*, DISSENT, Spring 2018, at 23, 24.

citizenry. Cost-efficiency tools—that rely on deploying markets in a more targeted and efficient way that could have been activated—were simply left on the cutting room floor.⁶³

A. THE ACA AS AN ENDURING SPLIT DECISION

The ACA came on the scene on March 23, 2010 with one main goal: to increase access to health insurance, and ultimately, health care, for its populace.⁶⁴ It accomplished this by (1) initially mandatorily, and then voluntarily (after *NFIB v. Sebelius*),⁶⁵ asking states to expand their Medicaid programs, and (2) building a private insurance marketplace, known as an exchange or marketplace, for citizens who lacked health insurance—largely due to work, financial, or health status—to purchase health insurance with the assistance of governmental subsidies. These two goals have worked to drastically lower the number of uninsured individuals.⁶⁶ They have also shifted societal norms.⁶⁷ “Preexisting condition” has become a term firmly ensconced in public discourse.⁶⁸ Admirably, and undeniably, the ACA went further to improve health care access than any federal reform since the Medicare and Medicaid programs were conceived as part of President Lyndon B. Johnson’s Great Society in 1965.⁶⁹

The balance of this analysis focuses on the newly constructed federal marketplace. In order to build the marketplace, the federal government required

63. See *supra* notes 54–55 and accompanying text.

64. The United States still lags behind many other countries on quality and cost measures, largely related to insurance coverage. See Olga Khazan, *What’s Actually Wrong With the U.S. Health System*, ATLANTIC (July 14, 2017), <https://www.theatlantic.com/health/archive/2017/07/us-worst-health-care-commonwealth-2017-report/533634/> (“The ways to fix these issues . . . are to increase the rate of insurance coverage and access to primary care, streamline the insurance system so that there are less administrative hurdles for doctors, and funnel more money toward better nutrition and housing, rather than specialty care.”).

65. 567 U.S. 519 (2012).

66. By the end of 2015, more than 19 million Americans had gained health insurance due to the ACA. See BOWEN GARRETT & ANUJ GANGOPADHYAYA, WHO GAINED HEALTH INSURANCE COVERAGE UNDER THE ACA, AND WHERE DO THEY LIVE?, ROBERT WOOD JOHNSON FOUND. & URB. INST. 4 (2016), <https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf>.

67. See Kristen Bialik, *More Americans Say Government Should Ensure Health Care Coverage*, PEW RES. CTR. (Jan. 13, 2017), <http://www.pewresearch.org/fact-tank/2017/01/13/more-americans-say-government-should-ensure-health-care-coverage/> (“Currently, 60% of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38% who say this should not be the government’s responsibility. The share saying it is the government’s responsibility has increased from 51% last year and now stands at its highest point in nearly a decade.”).

68. See Jackie Farwell, *Mainers, Here are the Basics on Pre-Existing Medical Conditions*, BANGOR DAILY NEWS (May 10, 2017), <http://vitalsigns.bangordailynews.com/2017/05/10/affordable-care-act/mainers-here-are-the-basics-on-pre-existing-medical-conditions/> (“The term is insurance company jargon but it’s quickly becoming part of the popular lexicon.”).

69. See Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 978 (2002) (“Begun in 1965 as a virtual afterthought to the Social Security Act’s Medicare Program, Medicaid was enacted as a part of President Lyndon Johnson’s ‘Great Society’ legislation to provide access to healthcare for America’s poor, disabled and elderly.” (footnotes omitted)).

the private individual health insurance market to undertake a grand reorganizing through dense new regulations, one in which participating insurance companies consented to cover preventive care services,⁷⁰ essential health benefits,⁷¹ and individuals with preexisting conditions,⁷² all while agreeing to abstain from medical underwriting,⁷³ which had previously allowed insurance companies to “price in” the amount of risk that each beneficiary represented.⁷⁴ To sweeten the deal, the federal government promised to heavily subsidize the new market,⁷⁵ to protect the companies from uncertainty,⁷⁶ and, most importantly, to force millions of Americans—notably, healthy ones—into the market.⁷⁷

But what the law did not do was constrict the price of health care *on the front end* in any meaningful way.⁷⁸ Although they were considered, no cost-constricting mechanisms were ultimately adopted.⁷⁹ In other words, the ACA

70. See *Background: The Affordable Care Act's New Rules on Preventive Care*, CTRS. FOR MEDICARE AND & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background.html> (last visited Jan. 24, 2020) (documenting information about preventive care coverage).

71. See *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/cciio/resources/data-resources/ehb.html> (last visited Jan. 24, 2020); Shelby Livingston, *Most ACA Exchange Plans Feature a Narrow Network*, MOD. HEALTHCARE, (Dec. 4, 2018, 12:00 AM), <https://www.modernhealthcare.com/article/20181204/NEWS/181209976>.

72. See *The Politics of Pre-Existing Conditions*, WEEK (Dec. 1, 2018), <https://theweek.com/articles/809983/politics-preexisting-conditions> (“The Affordable Care Act . . . bars insurers from denying coverage or charging higher premiums to individuals with pre-existing conditions.”).

73. See Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 MICH. J.L. REFORM 685, 687–88 (1999) (describing medical underwriting as risk rating applicants based on age and health status and of deploying practices that limits enrollment of those with preexisting conditions); Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 527, 533 (2011) (describing underwriting as actuarial rating, which is “a system of pricing insurance premiums based on an individual’s likelihood of utilizing covered medical care”).

74. See Rosenbaum et al., *supra* note 73, at 533–34.

75. See *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAM. FOUND. (Nov. 20, 2018), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>.

76. See Cynthia Cox et al., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, KAISER FAM. FOUND. (Aug. 17, 2016), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/> (“The program worked by cushioning insurers participating in exchanges and marketplaces from extreme gains and losses.”).

77. *Questions and Answers on the Individual Shared Responsibility Provision*, IRS, <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision> (last visited Jan. 24, 2020). The individual mandate has since been repealed. See Robert Pear, *Individual Mandate Now Gone, G.O.P. Targets the One for Employers*, N.Y. TIMES (Jan. 14, 2018), <https://www.nytimes.com/2018/01/14/us/politics/employer-mandate.html>.

78. Prices continue to rise. See Brad Tuttle, *Here's What's Happened to Health Care Costs in America in the Obama Years*, TIME (Oct. 4, 2016), <http://time.com/money/4503325/obama-health-care-costs-obamacare/>.

79. See Helen A. Halpin and Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFF. 1117, 1119 (2010), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0363> (noting that the public option was “omitted” from the final legislation adopted that would become the Affordable Care Act). Nonetheless, the public option has been in and out of the public consciousness during health policy debates since 2010. See, e.g., Hillary Clinton, *My Vision for Universal, Quality, Affordable Health Care*, NEW ENG. J. MEDICINE (Oct. 27, 2016), <http://www.nejm.org/doi/full/10.1056/NEJMsbl612292> (“And finally, we need to ensure the availability of a public option choice in every state, and let Americans over 55 buy in to Medicare.”); see also Reed Abelson and Margot Sanger-Katz, *The Health Care “Public Option” Is Back. Can It Help*

does not tell pharmaceutical companies or hospitals how much to charge for certain services, nor does it adequately empower America's payers to aggressively negotiate; instead, it seeks to insulate Americans from painful expenditures. As a result, the ACA's popularity and effectiveness are largely impacted by two factors: (1) how many additional people have achieved health insurance access because of its provisions; and (2) how expensive and burdensome those insurance plans—and the concomitant care that accompanies those plans—are for these new beneficiaries. On this second factor, this is where the architecture of the marketplace has become paramount.

1. *The Undeniable Accomplishment of Access*

Reading the public statements that accompanied its passage in 2010, one would think that the ACA represented the “end of history”⁸⁰ for America's journey toward universal access to health care for its citizens. Before the final House vote on the ACA, Speaker Nancy Pelosi—who, more than any other legislator, deserves praise for its passage⁸¹—said “[t]oday we have the opportunity to complete the great unfinished business of our country.”⁸² Indeed, as has been said, it may have been “the most important event of the Obama presidency.”⁸³

President Obama was less sanguine. “This legislation will not fix everything that ails our health care system, but it moves us decisively in the right direction,” he said upon its passage.⁸⁴ In a statement striking for its multiple *post hoc* translations—both conveying the gravity of the moment and recognizing the incremental nature of its reform—Obama noted that “[t]his is what change looks like.”⁸⁵ Vice President Joe Biden was less measured, but surely more colorful.⁸⁶

Obamacare?, N.Y. TIMES (Sept. 29, 2016), <https://www.nytimes.com/2016/09/29/upshot/the-health-care-public-option-is-back-can-it-help-obamacare.html> (noting that, in 2010, the public option “was a no-go even with Democratic control of both branches [of Congress] in 2010”); Mara Gay, *Why Lieberman Hates the Public Option*, ATLANTIC (Oct. 28, 2009), <https://www.theatlantic.com/politics/archive/2009/10/why-lieberman-hates-the-public-option/347740/> (“The public option was on a roll. Then, on Tuesday, Sen. Joe Lieberman threatened to filibuster the health care bill if it includes a public option, which he says would create ‘trouble for taxpayers, for the premium payers and for the national debt.’”). The election of the Scott Brown to the Senate in Massachusetts served as “a death blow to the public option.” Bob Cusack et al., *The Chaotic Fight for ObamaCare*, HILL (Feb. 10, 2016, 6:00 AM), <http://thehill.com/policy/healthcare/268877-the-chaotic-fight-for-obamacare>.

80. See FRANCIS FUKUYAMA, *THE END OF HISTORY AND THE LAST MAN* (1992) (arguing that liberal democracy could signify the end of “ideological evolution,” or the “end of history”).

81. See Cusack et al., *supra* note 79.

82. See Karen Tumulty, *Making History: House Passes Health Care Reform*, TIME (Mar. 23, 2010), <http://content.time.com/time/politics/article/0,8599,1973989,00.html>.

83. See David Blumenthal et al., *The Affordable Care Act at Five Years*, 372 NEW ENG. J. MED. 2451, 2451 (2015), <http://www.nejm.org/doi/full/10.1056/NEJMhpr1503614>.

84. See Tumulty, *supra* note 82 (internal quotation marks omitted).

85. *Id.* Ewen MacAskill, *Barack Obama's Healthcare Bill Passed by Congress*, GUARDIAN (Mar. 22, 2010, 3:30 PM), <https://www.theguardian.com/world/2010/mar/22/us-healthcare-bill-passes-congress>.

86. See Brian Montopoli, *Biden Swears at Bill Signing: Just Biden Being Biden?*, CBS NEWS (Mar. 23, 2010, 2:18 PM), <https://www.cbsnews.com/news/biden-swears-at-bill-signing-just-biden-being-biden/> (describing Vice President Biden as telling President Obama that “passage of the bill is a ‘big [fucking] deal’”).

And regarding structural access to health care, Biden was right: the ACA has been a game-changer.⁸⁷ It has ushered in rapid changes to America's complex health insurance system. Millions of Americans have gained access to insurance through massive expansions,⁸⁸ accomplished both by (1) Medicaid expansion and (2) the individual exchange, in which federal government-funded tax subsidies and cost sharing reduction payments help citizens pay for health insurance and care.⁸⁹ The law has been "surprisingly resilient,"⁹⁰ perhaps most tellingly on the score of health care insurance coverage, even after regulatory changes brought about by the Trump administration shrunk the number of insured Americans,⁹¹ and made health insurance both more expensive and harder to find.⁹² More recent proposals from the Trump administration will likely continue this trend.⁹³

On perhaps its most important metric, by just the third year of the ACA's implementation, the American uninsurance rate had dropped to 10.3% of the U.S. population.⁹⁴ This was a stark change from the historic uninsurance rate for the two decades preceding the ACA's passage, during which the rate had reliably

87. See generally GARRETT & GANGOPADHYAYA, *supra* note 66 (offering an overview on the positive change the ACA has brought).

88. *Id.* at 7.

89. See Linda Qiu, *Calling Cost-Sharing Reduction Payments "a Bailout" Is Misleading*, N.Y. TIMES (Oct. 18, 2017), <https://www.nytimes.com/2017/10/18/us/politics/cost-sharing-reductions-bailout.html>; John Ydstie, *How the Affordable Care Act Pays for Insurance Subsidies*, NPR (Nov. 7, 2013, 2:57 AM), <https://www.npr.org/sections/health-shots/2013/11/07/243584170/how-the-affordable-care-act-pays-for-insurance-subsidies>.

90. Peter Sullivan, *ObamaCare Proves Surprisingly Resilient*, HILL (Dec. 25, 2017, 5:57 AM), <http://thehill.com/policy/healthcare/366239-obamacare-proves-surprisingly-resilient>; see also Harold Pollack, *Republicans Couldn't Kill Obamacare. That's the Genius of Its Design.*, WASH. POST (Mar. 29, 2017), https://www.washingtonpost.com/posteverything/wp/2017/03/29/republicans-couldnt-kill-obamacare-thats-the-genius-of-its-design/?utm_term=.d421a6699c6d ("And in doing so, it has quietly embedded itself within the fabric of American life—and has become very difficult for politicians to kill.").

91. Nonetheless, the changes were not as impactful as originally feared. See *National ACA Marketplace Signups Dipped a Modest 3.7 Percent This Year*, KAISER FAM. FOUND. (Feb. 7, 2018), <https://www.kff.org/health-reform/press-release/national-aca-marketplace-signups-dipped-a-modest-3-7-percent-this-year/>.

92. *Id.* (noting that more than 11.7 million Americans signed up for health insurance on the ACA exchange, "amid steep reductions in federal funding for outreach and navigators, an enrollment period half as long, and a climate of political uncertainty surrounding the law").

93. See Margot Sanger-Katz, *A Big Divergence Is Coming in Health Care Among States*, N.Y. TIMES (Feb. 28, 2018), <https://www.nytimes.com/2018/02/28/upshot/health-care-obamacare-states-divergence.html> ("Taken together, experts say, the administration's actions will tend to increase the price of health insurance that follows all the Affordable Care Act's rules and increase the popularity of health plans that cover fewer services. The result could be divided markets, where healthier people buy lightly regulated plans that don't cover much health care, lower earners get highly subsidized Obamacare—and sicker middle-class people face escalating costs for insurance with comprehensive benefits.").

94. *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 7, 2018), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> (this uninsurance rate amounts to about 28 million people).

hovered between 16% and 18% of the population.⁹⁵ In an access battle that had been fought for generations,⁹⁶ the ACA made real headway.

Of course, most of the heaviest lifting was accomplished by the relentlessly battered Medicaid program.⁹⁷ By November of 2018, thirty-six states and the District of Columbia—a high-water mark⁹⁸—had expanded their workhorse Medicaid programs under the ACA,⁹⁹ additionally insuring a total of more than 11 million beneficiaries.¹⁰⁰ By the end of 2018, only fourteen states—concentrated in the southeast and central plains—had not expanded Medicaid.¹⁰¹

Largely driven by its expansion under the ACA, by the end of 2017, Medicaid covered approximately 74 million beneficiaries—up from about 57 million before the ACA was passed.¹⁰² As of 2018, more than 20% of Americans received insurance through Medicaid, and, judging from public polling and various other developments, this number may yet grow in the future.¹⁰³ Vitaly,

95. *Id.*

96. Health care access was slowly extended to more and more groups of Americans since the advent of Medicare and Medicaid in 1965. See, e.g., *Eligibility*, MEDICAID & CHIP PAYMENT & ACCESS COMMISSION, <https://www.macpac.gov/medicaid-101/eligibility/> (last visited Jan. 24, 2020) (“Between 1984 and 1990, however, Congress made a number of changes that expanded Medicaid for pregnant women and children.”).

97. The American Health Care Act—the bill that passed the Republican-led House of Representatives—would have installed a per capita cap on the safety net program. See Julia Paradise, *Restructuring Medicaid in the American Health Care Act: Five Key Considerations*, KAISER FAM. FOUND. (Mar. 15, 2017), <https://www.kff.org/medicaid/issue-brief/restructuring-medicaid-in-the-american-health-care-act-five-key-considerations/>.

98. Medicaid expansion is cheaper for the federal government than paying for premium-assistant tax credits for the ACA’s individual exchange. See Susannah Luthi, *ACA Subsidies Cost More Per Person Than Medicaid. Is that Sustainable?*, MOD. HEALTHCARE (Aug. 8, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180808/NEWS/180809915> (“The CBO’s latest projection from earlier this year show government paying out an average of \$6,300 annually for every subsidized enrollee in fiscal 2018. It estimates that number will rise to nearly \$12,500 in 2028. In contrast, Medicaid spends \$4,230 per non-disabled adult, set to inflate at 5.2% annually to just over \$7,000 per person in 2028.”).

99. *Status of State Medicaid Expansion Decision: Interactive Map*, KAISER FAM. FOUND. (Sept. 20, 2019), <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

100. See Leighton Ku et al., *Data Note: Medicaid’s Role in Providing Access to Preventive Care for Adults*, KAISER FAM. FOUND. (May 17, 2017), <https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/>.

101. See *Status of State Medicaid Expansion Decision: Interactive Map*, *supra* note 99.

102. *Total Monthly Medicaid and CHIP Enrollment*, KAISER FAM. FOUND. (June 2019), <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

103. See Joel Ebert & Dave Boucher, *Behind Closed Doors, Haslam Asks Again: Can Tennessee Expand Health Care for Working Poor?*, TENNESSEAN, <https://www.tennessean.com/story/news/politics/2018/04/13/can-tennessee-expand-health-care-working-poor-haslam-asks-behind-closed-doors/511878002/> (last updated Apr. 13, 2018, 2:52 PM; Mallory Noe-Payne, *Medicaid Expansion in Virginia Inches Closer to Reality*, WVTF (Apr. 6, 2018), <http://wvtf.org/post/medicaid-expansion-virginia-inches-closer-reality>; *Texans Want to Expand Medicaid. Politicians Don’t*, HOUS. CHRON. (Sept. 14, 2018, 4:47 PM), <https://www.houstonchronicle.com/opinion/editorials/article/Texans-want-to-expand-Medicaid-Politicians-13228093.php>.

expanding coverage for the Medicaid population is likely to translate into increases in the amount of individuals receiving preventive care.¹⁰⁴

The ACA has made the most progress in states that have implemented the Medicaid expansion and supported their individual private health insurance exchanges. For example, California's uninsured rate had dropped from 17% before the implementation of the ACA to 6.8% during the middle of 2017.¹⁰⁵ After the first few years of the ACA, Illinois' uninsured population had shrunk from 1.6 million to just 817,000.¹⁰⁶ Large swaths of Oregon, Nevada, New Mexico, southern Colorado, southwest Texas, and Arkansas have shown double-digit jump in health insurance rates since its passage.¹⁰⁷

In addition to broadening access to health insurance, the ACA also deepened the quality of health insurance coverage. The ACA made preventive care and chronic disease treatment—in addition to a number of other treatments—available to millions of Americans.¹⁰⁸ Under the law, non-grandfathered insurance plans cover—without any cost sharing—a number of preventive cancer screenings, chronic condition screenings, immunizations, counseling services, pre-natal screenings and supports, and contraception and reproductive health screenings and counseling.¹⁰⁹

The ACA reformed the individual marketplace from the inside-out, adding to the number of plans with comprehensive coverage. Most notably, the ACA prohibited annual and lifetime limits for health insurance plans,¹¹⁰ outlawed preexisting conditions,¹¹¹ and banned medical underwriting.¹¹² In a noteworthy

104. See Miguel Marino et al., *Receipt of Preventive Services After Oregon's Randomized Medicaid Experiment*, 50 AM. J. PREVENTATIVE MED. 161 (2016) (“[T]his study demonstrates a causal relationship between Medicaid coverage and receipt of several preventive services in CHC patients, including receipt of breast and cervical cancer screenings as well as screenings for BMI, blood pressure, and smoking, during a three-year follow up.”).

105. See Cathie Anderson, *California's Uninsured Rate Drops to New Low*, SACRAMENTO BEE (Nov. 21, 2017, 5:00 AM), <http://www.sacbee.com/news/local/health-and-medicine/article185812078.html>.

106. See Lisa Schencker, *Illinois Uninsured Rate Falls Again—But for How Long?*, CHI. TRIB. (Sept. 12, 2017), <http://www.chicagotribune.com/business/ct-health-insurance-coverage-increases-0913-biz-20170912-story.html>.

107. See Kevin Quealy and Margot Sanger-Katz, *Obama's Health Law: Who Was Helped Most*, N.Y. TIMES (Oct. 29, 2014), <https://www.nytimes.com/interactive/2014/10/29/upshot/obamacare-who-was-helped-most.html>.

108. *Key Facts About the Uninsured Population*, supra note 94.

109. *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, KAISER FAM. FOUND. (Aug. 4, 2015) <https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>.

110. *Lifetime & Annual Limits*, HEALTH & HUM. SERVS., <https://www.hhs.gov/healthcare/about-the-aca/benefit-limits/index.html> (last updated Jan. 31, 2017).

111. *Pre-Existing Conditions*, HEALTH & HUM. SERVS., <https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html> (last updated Jan. 31, 2017).

112. Gary Claxton et al., *Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, KAISER FAM. FOUND. (Dec. 12, 2016) <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/> (“Prior to 2014 medical underwriting was permitted in the individual insurance market in 45 states and DC.”). See Hall, supra note 73 (noting that medical underwriting is risking rating applicants based on age and health status and of limiting enrollment of those with preexisting conditions).

regulatory provision, the ACA also strictly limited the profits that health insurance companies can pocket on the exchanges through medical-loss ratio regulations.¹¹³

2. Cost Expenditure Growth

It is a well-worn refrain by now: American health care is too expensive.¹¹⁴ The country spends \$3.6 trillion annually on health care, which amounts to \$11,172 per person.¹¹⁵ It now accounts for 17.7% of the gross domestic product (GDP).¹¹⁶ And it will continue to grow in stature. American health expenditures are forecasted to hit \$6 trillion, and nearly 20% of the GDP, by 2027.¹¹⁷ America spends more, on average, than any other peer country.¹¹⁸ Indeed, the trends are certainly worsening. The United States' gap in health care spending—between it and every other country—has precipitously widened over the last 50 years.¹¹⁹

The ACA's ability to positively impact the cost of American health care has been "mixed."¹²⁰ From a global perspective, the growth of national health expenditures rose with the implementation of the ACA, and then slowed in 2016.¹²¹ In 2016, both "the federal government and households accounted for the largest shares of health care spending," each responsible for 28% of overall health care expenditures.¹²²

113. *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, KAISER FAM. FOUND. (Feb. 29, 2012) <https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/>.

114. See Austin Frakt, *Medical Mystery: Something Happened to U.S. Health Spending After 1980*, N.Y. TIMES (May 14, 2018), <https://www.nytimes.com/2018/05/14/upshot/medical-mystery-health-spending-1980.html?hp&action=click&pgtype=Homepage&clickSource=image&module=second-column-region®ion=top-news&WT.nav=top-news>. Recent work has suggested that America's health care cost spending became anomalous—as compared to other countries—starting in 1980. *Id.*

115. See *National Health Expenditure Data: Historical*, CTMS. FOR MEDICARE & MEDICAID SERVS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last updated Dec. 17, 2019).

116. *Id.*

117. See *National Health Expenditure Projections 2018–2027*, CTMS. FOR MEDICARE & MEDICAID SERVS. (Feb. 20, 2019), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf>.

118. See Bradley Sawyer and Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries?*, PETERSON-KAISER HEALTH SYS. TRACKER (Dec. 7, 2018) https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/?_sf_s=health+spending#item-start. Switzerland, the second-highest-spending country, allocates \$8009 per person annually on health care. *Id.* Third-place Germany spends just over \$5700—roughly half of what the United States spends. *Id.* The United Kingdom spends only \$4246 annually; the “comparable country average” of other first-world countries surveyed totals around \$5280. *Id.*

119. See *id.*

120. See Tuttle, *supra* note 78.

121. See Micah Hartman et al., *National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions*, 37 HEALTH AFF. 150, 151–52 (2017) (showing that national health expenditures grew 4.1% in 2010, 3.5% in 2011, 4.0% in 2012, 2.9% in 2013, 5.1% in 2014, 5.8% in 2015, and 4.3% in 2016). The “faster growth in 2014 and 2015 is associated with coverage expansions under the Affordable Care Act (ACA) and strong retail prescription drug spending growth.” *Id.* at 150.

122. *Id.* at 154.

A recent study showed that out-of-pocket expenditures dropped nearly 12% following the increases in insurance coverage, but “premium contributions” increased by 12%.¹²³ Individuals earning more than 400% of the federal poverty level have faced as much as a 23% increase in premiums in the two years since ACA implementation.¹²⁴ These are individuals, thanks to the ACA’s subsidy structure, who face the entirety of cost premium increases.¹²⁵

Clearly, these numbers indicate that the law has benefitted the poorest Americans—reducing their out-of-pocket spending by more than 21%—but caused “middle-income households [to see] a 28 percent jump in high-burden premium spending,”¹²⁶ leading the study’s lead author to note that the ACA has “reduced out-of-pocket costs,” but failed to “stem the steady rise in families’ premiums,” and “there is plenty of room for progress.”¹²⁷ Further, “out-of-pocket spending by consumers on health costs not covered by insurance rose 3.9 percent [in 2016] compared with 2.8 percent in 2015.”¹²⁸

Regarding the individual market, those signing up for health insurance on the health insurance exchange have been subject to repeated premium jumps. In Tennessee, for example, carrier BlueCross BlueShield requested a 62% average increase in 2017 and 21% average increase in 2018.¹²⁹ Cigna requested a 46% increase in 2017 and a 42% increase in 2018.¹³⁰ A third carrier, Humana, requested a 44% increase in 2017, and exited the markets in 2018.¹³¹

Although subject to a number of uniquely-affecting characteristics, premiums—for silver plans on the ACA exchanges—have recently made headlines because they are decreasing.¹³² But other plans’ premium increases—undoubtedly impacted by regulatory and enforcement changes brought about by

123. Anna Goldman et al., *Out-of-Pocket Spending and Premium Contributions After Implementation of the Affordable Care Act*, 178 JAMA INTERNAL MED. 347, 348 (2018).

124. See Dan Mangan, *Out-Of-Pocket Health Spending Dropped by Nearly 12 Percent—But Premiums Rose After Obamacare Roll Out*, CNBC, <https://www.cnbc.com/2018/01/22/out-of-pocket-health-spending-dropped-after-obamacare-rolled-out.html> (last updated Jan. 22, 2018, 3:20 PM). In 2018, 400% of federal poverty level for a family of two is approximately \$66,000 per year, and for a family of four, it is about \$100,000 of annual income. See *Federal Poverty Guidelines*, FAMILIES USA, (July 2018) <https://familiesusa.org/product/federal-poverty-guidelines>.

125. See *infra* notes 189–202 and accompanying text.

126. Mangan, *supra* note 124.

127. *Id.*

128. See Toni Clarke, *U.S. Healthcare Spending Growth Slowed in 2016*, REUTERS (Dec. 6, 2017, 1:07 PM), <https://www.reuters.com/article/us-usa-healthcare-report/u-s-healthcare-spending-growth-slowed-in-2016-idUSKBN1E031D>.

129. See Holly Fletcher, *Tennessee’s ACA Market “Even Less Secure” After Failed Repeal, Insurance Chief Frets*, TENNESSEAN, <https://www.tennessean.com/story/money/industries/health-care/2017/07/28/mcpeak-questions-congressional-shore-up-aca-market-after-repeal-defeat/520001001/> (last updated July 28, 2017, 4:34 PM).

130. *Id.*

131. *Id.*

132. See Rachel Fehr et al., *How ACA Marketplace Premiums Are Changing by County in 2019*, KAISER FAM. FOUND. (Nov. 20, 2018), <https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2019/>.

the Trump administration—are substantial.¹³³ For example, for the 2018 market, a carrier in Georgia requested an average rate increase of 34.5%,¹³⁴ one in Maryland requested one at more than 45%,¹³⁵ multiple Michigan carriers requested increases ranging from 13% to about 27%,¹³⁶ respectively, New Mexico’s carriers requested increases of 21%, 33%, and 49%,¹³⁷ respectively, and one in Virginia requested an increase of 21.5 percent, with another requesting an increase above 54%.¹³⁸ According to Kaiser:

Looking back to 2014 . . . reveals a wide range of premium changes. In many of these cities, average annual premium growth over the 2014-2018 period has been modest, and in two cities . . . benchmark premiums have actually decreased. In other cities, premiums have risen rapidly over the period, though in some cases this rapid growth was because premiums were initially quite low.¹³⁹

For 2018, the premium shift for benchmark silver plans was expected to range from negative 5% to 49% across twenty-one major American cities.¹⁴⁰ Nonetheless, according to a 2017 HHS report, the “average individual market premiums more than doubled from \$2,784 per year in 2013 to \$5,712 on healthcare.gov in 2017.”¹⁴¹ Three states saw their average premiums triple from 2013 to 2017.¹⁴²

This trend may continue. In the spring of 2018, early reporting on preliminary premium increases for 2019 indicated that “insurers requested hikes as high as 64.3 percent” in Virginia, about 11% in Vermont, and about 11% in Maryland.¹⁴³ One plan in Maryland reportedly listed a 91.4% premium increase.¹⁴⁴ But some markets are expected to stabilize, likely resulting in smaller premium increases.¹⁴⁵

133. See Rabah Kamal et al., *An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges*, KAISER FAM. FOUND., (Aug. 10, 2017), <https://www.kff.org/health-reform/issuebrief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.* Further, the number of participating insurers has changed, decreasing from nearly seven in 2015 to 4.6 in 2018. *Id.* See Fehr et al., *supra* note 132 (noting the number of insurance companies participating by state has decreased).

139. See Kamal et al., *supra* note 133.

140. *Id.*

141. See *HHS Report: Average Health Insurance Premiums Doubled Since 2013*, U.S. DEP’T HEALTH & HUM. SERVS. (May 23, 2017), <https://www.hhs.gov/about/news/2017/05/23/hhs-report-average-health-insurance-premiums-doubled-2013.html>.

142. *Id.* The three states were Alaska, Alabama, and Oklahoma, according to the Department of Health and Human Services. *Id.*

143. Catherine Rampell, *This Is What a Death Spiral Looks Like*, WASH. POST (May 14, 2018), https://www.washingtonpost.com/opinions/this-is-what-a-death-spiral-looks-like/2018/05/14/07cea4cc-57b3-11e8-8836-a4a123c359ab_story.html.

144. *Id.*

145. See Jessica Seaman, *As Colorado’s Insurance Market Stabilizes, Officials Expect Premium Increases to Be Lower Than Years’ Past*, DENVER POST (Dec. 18, 2018), <https://www.denverpost.com/2018/12/18/colorado-insurance-market-premiums/>; see, e.g., Kristi L. Nelson,

Indeed, tax subsidies on the individual marketplace insulate the typical consumer from feeling the worst effects of those price increases.¹⁴⁶ As the National Conference of State Legislatures noted, the average increase before subsidies was a shocking 25%.¹⁴⁷ These increases have improved profitability for insurance companies, increasing the monthly gross margins per member.¹⁴⁸

But premium calculations are only one side of the equation; deductibles of the individual exchange plans have risen while the networks of coverage have narrowed.¹⁴⁹ In 2018, the average deductible for an ACA exchange silver plan was \$3937, an increase from \$3703 in 2017, even though bronze plan deductibles were decreasing.¹⁵⁰ Nonetheless, “the reality is, the American insurance system is designed to make health care financially unpleasant, often to the point where patients forgo necessary care.”¹⁵¹ Relatedly, “90 percent of all people on the exchanges still pay deductibles in excess of \$1,300 individually or \$2,600 per family, amounts that are often difficult to afford even for middle-class families.”¹⁵²

Financial discomfort has not been limited to the individual marketplace. Similar premium price increases are present in employer-based health insurance, with the average cost of an “employer-sponsored family plan” totaling \$12,680 in 2008, and rising to \$18,142 by 2016.¹⁵³ The average worker was responsible for \$3354 in premium costs in 2008, and in 2016, the average worker was responsible for premium amounts at \$5277.¹⁵⁴ More than half (51%) of survey

Obamacare: Lower ACA Premiums, More Options Likely for Tennesseans in 2019, KNOXVILLE NEWS-SENTINEL (July 12, 2018, 5:16 PM), <https://www.knoxnews.com/story/news/health/2018/07/12/obamacare-tennessee-lower-premiums-aca-2019/779414002/> (noting a reduction in premiums for 2019 individual exchange proposals).

146. See Rampell, *supra* note 143 (“Most exchange enrollees will be shielded from premium increases thanks to income-based subsidies, and despite Democratic fever dreams, voters don’t seem all that motivated by health care.”).

147. *Health Insurance: Premium and Increases*, NAT’L CONF. ST. LEGISLATURES (Dec. 4, 2017), <http://www.nesl.org/research/health/health-insurance-premiums.aspx>.

148. See Cynthia Cox et al., *Individual Insurance Market Performance in 2018*, KAISER FAM. FOUND. (May 7, 2019), <https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2018/> (“On average, premiums per enrollee grew 26% from 2017 to 2018, while per person claims grew only 7%.”).

149. See Dan Mangan, *Obamacare Plans Get More Restrictive and Deductibles Get Pricier in 2018*, CNBC, <https://www.cnbc.com/2017/11/30/obamacare-plans-get-narrower-and-deductibles-get-pricier-in-2018.html> (last updated Nov. 30, 2017, 4:31 PM).

150. *Id.*

151. Vann R. Newkirk II, *The American Health-Care System Increases Income Inequality*, ATLANTIC (Jan. 19, 2018) <https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/> (“The ACA helped reduce total bankruptcies by as many as 1.5 million between 2010 and 2017. The Centers for Disease Control and Prevention reports that, between 2011 and 2016, the percentage of Americans with trouble paying medical bills dropped precipitously.”).

152. *Id.*

153. See Tuttle, *supra* note 78; see also *Average Annual Workplace Family Health Premiums Rise Modest 3% to \$18,142 in 2016; More Workers Enroll in High-Deductible Plans with Savings Option over Past Two Years*, KAISER FAM. FOUND. (Sept. 14, 2016) [hereinafter *Average Annual Workplace Family Health Premiums Rise*] <https://www.kff.org/health-costs/press-release/average-annual-workplace-family-health-premiums-rise-modest-3-to-18142-in-2016-more-workers-enroll-in-high-deductible-plans-with-savings-option-over-past-two-years/>.

154. See Tuttle, *supra* note 78.

respondents reported that their health insurance deductibles exceeded \$1000.¹⁵⁵ This cost is up from 16% in 2006 and 35 percent in 2008.¹⁵⁶ Relatedly, 83% of those employed reported that their single coverage carries a deductible, and its average amount is \$1478.¹⁵⁷ In 2015, the average deductible for the same type of insurance was \$159 less, and in 2011, it was \$486 less.¹⁵⁸

Nonetheless, the 2016 data could very well paint a brighter picture. Survey results from 2016 indicated that between 2011 and 2016, health care insurance family premiums rose 20%, which “reflect[ed] a significant slowdown,” as premiums rose 31% from 2006 to 2011, and 63% from 2001 to 2006.¹⁵⁹ Further, according to President Barack Obama’s White House, increases in premiums are much lower than they would have been without the passage and implementation of the ACA.¹⁶⁰ In short, the White House argued that

Structural changes in the health care system . . . reduced health care spending growth relative to the past. . . . It is therefore increasingly likely that structural changes in the health care system—including changes in public policy and other factors that would have a persistent effect on health care spending over the long run—are the primary reasons health care cost growth remains low today.¹⁶¹

Finally, it has been argued that, as the deductible rate has risen, the “share [families in employer coverage] bear in the form of co-payments and co-insurance has actually *fallen* steadily in recent years.”¹⁶²

Other works have acknowledged the fact that provisions within the ACA have “thus far yielded modest cost savings” and that the law has not ushered in a “return to the double-digit increases of the past.”¹⁶³ Nonetheless, “little evidence” has been found to support the idea “that ACA cost containment provisions produced changes necessary to ‘bend the cost curve.’”¹⁶⁴ Indeed, at least two major trends complicate the data: (1) the years leading up to the implementation of the ACA were impacted by the 2007–2009 recession;¹⁶⁵ and

155. See *Average Annual Workplace Family Health Premiums Rise*, *supra* note 153.

156. See Tuttle, *supra* note 78.

157. See *Average Annual Workplace Family Health Premiums Rise*, *supra* note 153.

158. *Id.*

159. *Id.*

160. See Jason Furman & Matt Fiedler, *New Data Show that Premium Growth in Employer Coverage Remained Low in 2016*, WHITE HOUSE BLOG (Sept. 14, 2016, 12:00 PM), <https://obamawhitehouse.archives.gov/blog/2016/09/14/new-data-show-premium-growth-employer-coverage-remained-low-2016>, noting:

Sustained slow premium growth is generating major benefits for families. Had premium growth since 2010 matched the average rate recorded over the preceding decade, the average total premium for employer-based family coverage would have been nearly \$3,600 higher in 2016. A large portion of these savings have accrued directly to workers in the form of lower premium contributions.

161. *Id.*

162. *Id.*

163. Janet Weiner et al., *Effects of the ACA on Health Care Cost Containment*, U. PA. LEONARD DAVIS INST. HEALTH ECON. ISSUE BRIEF (Mar. 2, 2017), <https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment>.

164. *Id.*

165. *Id.*

(2) the crush of additional insurance coverage in 2014 resulted in a substantial number of new beneficiaries.¹⁶⁶ Both trends obscure a cleaner causal story regarding the ACA's ability to contain the cost of American health care. It seems uncontroversial to assert that whether or not the ACA has been "good" for cost containment is subject to one's individual circumstances; nonetheless, it has surely not drastically improved the prices of American health care by reversing cost increases.

B. THE PRACTICAL IMPACT

In February 2018, it was the stony stare of thirty-year-old Gwen Hurd, set against melting snow and beneath a blaring *New York Times* headline, that communicated an unmistakable message.¹⁶⁷ Hurd's story—facing a 60% premium increase for its health insurance plan, her family turned to the ACA exchange,¹⁶⁸ where she and her husband could only find a plan with a monthly premium of \$928 and a \$6000 deductible¹⁶⁹—is all-too-familiar for millions of Americans who continue to struggle.¹⁷⁰ The glare, the snow, the weathered fence behind her, all of it,¹⁷¹ personify the persistent headwinds that continue to hamper the ACA.

So do the words of Teri Goodrich and her husband, John Kistle.¹⁷² Goodrich and Kistle, private consultants in their late fifties, were paying \$1600 per month in health care premiums and facing deductibles of \$7500 *each* before dropping their ACA-purchased insurance altogether.¹⁷³ They are now "trying to figure out how to make less than \$64,000 so [they] can get subsidies."¹⁷⁴ One could also add the story of Karen Poulter, a middle-aged biologist, who pays premiums totaling more than \$600 per month—in addition to her \$400 out-of-pocket prescription drug costs.¹⁷⁵ Her deductible is \$4000.¹⁷⁶ She gets no federal tax help either.¹⁷⁷

The Goodriches and Poulter of the world—representative of about 2.1 million Americans who have purchased non-subsidy assisted ACA

166. *Id.*

167. Goodnough, *supra* note 39.

168. *Id.*

169. *Id.*

170. See Rovner, *supra* note 36.

171. After toying with the idea of dropping their insurance, the feature ends with Ms. Hurd fortunately finding a new job that offered her health insurance with a \$300 monthly premium, avoiding the worst effects of an "Obamacare dilemma." Goodnough, *supra* note 39. Nonetheless, the plan carried a \$3000 individual deductible and a \$6000 deductible for her family. *Id.*

172. See Rovner, *supra* note 36.

173. *Id.*; see also *supra* notes 167–171 and accompanying text.

174. See Rovner, *supra* note 36.

175. See Dan Mangan, *Obamacare's Crushing Cost to Some Families: 49 Percent Price Hike Since 2014, Premiums of \$14,300*, CNBC, <https://www.cnbc.com/2017/05/11/these-folks-dont-get-obamacare-subsidies-now-and-it-is-really-costing-them.html> (last updated May 11, 2017, 6:05 PM).

176. *Id.*

177. *Id.*

coverage¹⁷⁸—may constitute a burning edge of the ACA.¹⁷⁹ They do not fit into the positive narrative of the ACA that has finally shown up in public polling of the law¹⁸⁰—its sparkling access expansions,¹⁸¹ health equity gains,¹⁸² and much-needed financial protections.¹⁸³ In short, the stories of Hurd, Goodrich, Kistle, and Poulter—representing insufficient insulation from the worst of the private market—illustrate the most potent long-term existential challenge for the ACA.

To be fair, the ACA's architects would be quick to note that Americans who receive health care on the individual exchanges—this year, an enrollment that approached 12 million Americans¹⁸⁴—receive tax subsidies to defray the costs of health insurance.¹⁸⁵ For the majority of Americans receiving premium assistance tax credits on the marketplace, most Americans avoid the full pain of rising premiums.¹⁸⁶ In the last couple of years, between 83% and 85% of Americans who had signed up on the ACA exchange for health insurance received a tax subsidy to dull the pain of the insurance premium increases¹⁸⁷—

178. See Rovner, *supra* note 36.

179. See Mangan, *supra* note 175 (“She’s echoed by Karen Poulter, a 51-year-old molecular biologist from California, who this year saw her health insurance premium jump 20 percent. She now pays almost \$618 per month for a plan that has a \$4,000 deductible and—because of health problems that include migraines and endometriosis—her prescription drug costs out-of-pocket are about \$400 each month.”).

180. The law has finally experienced an extended period—since the spring of 2017—where the public’s favorability of the ACA outpaces its unfavorability. See *Kaiser Health Tracking Poll: The Public’s Views on the ACA*, KAISER FAM. FOUND. (Oct. 15, 2019), <https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable—Unfavorable>.

181. See Kevin Griffith et al., *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, HEALTH AFF. BLOG, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0083> (last visited Jan. 24, 2020).

182. For instance, the Affordable Care Act has had an undeniably positive impact on the lives of those living with HIV/AIDS. See *The Affordable Care Act Helps People Living With AIDS*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hiv/policies/aca.html> (last updated Feb. 15, 2019).

183. See Annie Lowrey, *The Bankruptcies that Would Follow an Obamacare Repeal*, ATLANTIC (July 25, 2017), <https://www.theatlantic.com/business/archive/2017/07/health-care-financial-protection/534762/> (“[T]he Affordable Care Act saved her not just from cancer, but from financial ruin.”).

184. See Abby Goodnough, *The Final Obamacare Tally Is In. About 400,000 Fewer People Signed Up This Year*, N.Y. TIMES (Apr. 3, 2018), <https://www.nytimes.com/2018/04/03/health/obamacare-enrollment-insurance-trump.html>.

185. See Troy Griggs et al., *How Many People Are Affected by Obamacare Premium Increases? (Hint, It’s Fewer Than You Think)*, N.Y. TIMES (Mar. 9, 2017), <https://www.nytimes.com/interactive/2017/03/09/us/politics/who-is-really-affected-by-rising-obamacare-premiums.html>.

186. See THE DISTRIBUTION OF MAJOR TAX EXPENDITURES IN THE INDIVIDUAL INCOME TAX SYSTEM, CONG. BUDGET OFF. 14 fig.5 (2013), https://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf; see also Joseph Antos, *End the Exemption for Employer-Provided Health Care*, N.Y. TIMES, <https://www.nytimes.com/roomfordebate/2015/04/14/the-worst-tax-breaks/end-the-exemption-for-employer-provided-health-care> (last updated Dec. 6, 2016, 11:29 AM) (“Premiums paid for employer-sponsored health insurance are excluded from taxable income, reducing the amount workers owe in income and payroll taxes by about \$250 billion annually.”).

187. Notwithstanding the Trump administration’s decision to end different cost-sharing reduction (CSR) payments, the premium assistance tax credit subsidies do defray the cost of monthly insurance premiums for beneficiaries. See Pear, et al., *supra* note 17. In fact, in 2015, for those registering on healthcare.gov, “tax credits averaged \$263 a month and reduced the premium by 72 percent, on average.” See Robert Pear, *86 Percent of Health Law Enrollees Receive Subsidies, White House Says*, N.Y. TIMES (Mar. 10, 2015), <https://www.nytimes.com/2015/03/11/us/11-7-million-americans-have-insurance-under-health-act.html>.

technocratic analgesics unavailable to Hurd and her family, which, perhaps unsurprisingly, tends to breed resentment.¹⁸⁸

Nonetheless, the ACA's individual marketplace treats individuals in different income brackets radically different. Tightly calibrated, the exchange is heavily subsidized, with low earners being awarded the largest subsidies. The subsidy structure is a wonkish marvel, applying a sliding scale in an attempt to meet individuals in very different socioeconomic realities in different places.

But the ACA's subsidy structure has jagged cliffs. For example, based upon projections, a married couple with a \$60,000 household income seeking health insurance on the exchange would receive \$979 per month in subsidies and pay \$478 per month out-of-pocket for insurance premiums.¹⁸⁹ The same couple with a \$70,000 household income would receive no federal tax subsidy, and would have to pay approximately \$1457 per month in premiums.¹⁹⁰ As a result, the couple making \$60,000 would pay \$5736 annually in health care premiums; the couple making \$70,000 would pay \$17,484. In effect, the lower-earning couple would come out on top after health care premiums were paid.

This fragmentation prompts helplessness,¹⁹¹ resentment,¹⁹² and frustration,¹⁹³ among those who have seen drastic premium increases:

"Obamacare helped me," Ms. Griffith said. "I had a pre-existing condition, could not get insurance and had to pay cash, nearly \$30,000, for the birth of my first baby in 2010. For my second pregnancy in 2015, I was covered by Obamacare, and that was a huge financial relief." But the costs for next year, she said, are mind-boggling. She and her husband, both self-employed, expect to pay premiums of \$32,000 a year for the cheapest Optima plan available to their family in 2018. That is two and a half times what they now pay Anthem. And the annual deductible, \$14,400, will be four times as high. "I have no choice," Ms. Griffith said. "I agree that we need to make changes

Indeed, in the individual market, if the animating principle of the ACA is the drive to adequately shield beneficiaries from the full force of their insurance premium increases, the ACA seems to be working. *See* Newkirk II, *supra* note 151 (noting that some of the ACA's implemented policies "have been able to do some shielding").

188. *See id.* Mangan, *supra* note 175.

189. *See Health Insurance Marketplace Calculator*, KAISER FAM. FOUND. (Oct. 1, 2018), <https://www.kff.org/interactive/subsidy-calculator-2018/>.

190. *Id.*

191. *See* Robert Pear, *Middle-Class Families Confront Soaring Health Insurance Costs*, N.Y. TIMES (Nov. 16, 2017), <https://www.nytimes.com/2017/11/16/us/politics/obamacare-premiums-middle-class.html>.

192. *See* Julie Rovner, *Overlooked By ACA: Many People Paying Full Price for Insurance "Getting Slammed"*, KAISER HEALTH NEWS (Oct. 9, 2017), <https://khn.org/news/overlooked-by-aca-many-people-paying-full-price-for-insurance-getting-slammed/> ("We're getting slammed. We didn't budget for this."); *see also* Goodnough, *supra* note 39 ("It seems to me that people who earn nothing and contribute nothing get everything for free," said Ms. Hurd, 30. "And the people who work hard and struggle for every penny barely end up surviving."); Elisabeth Rosenthal, *Sorry, We Don't Take Obamacare*, N.Y. TIMES (May 14, 2016), <https://www.nytimes.com/2016/05/15/sunday-review/sorry-we-dont-take-obamacare.html> ("Yet even as many beneficiaries acknowledge that they might not have insurance today without the law, there remains a strong undercurrent of discontent.").

193. *See, e.g.,* Catherine Keefe, *I'm an Obama Supporter. But Obamacare Has Hurt My Family*, WASH. POST (Dec. 10, 2014), <https://www.google.com/amp/s/www.washingtonpost.com/amphtml/posteverything/wp/2014/12/10/im-an-obama-supporter-but-obamacare-has-hurt-my-family/>.

in the Affordable Care Act, but we don't have time to start over from scratch. We are suffering now."¹⁹⁴

People who are not assisted by the subsidies are those most directly financially affected by the spiraling cost of American health care, and, those effects are painful.¹⁹⁵

But what makes the pain worse is that not everyone—even those in a nearby socioeconomic neighborhood—is experiencing it.¹⁹⁶ The cutoffs between various financial cadres of households reflects state line-drawing.¹⁹⁷ Ms. Hurd exemplifies resentment that results when she says, “I’m totally happy to pay my fair share . . . but I’m also paying someone else’s share, and that’s what makes me insane.”¹⁹⁸ What is true, of course, is that forcing most Americans to pay their “fair share” for their health care would be completely unsustainable.

But the perception of unfairness persists because so many others are getting assistance.¹⁹⁹ Whether these beliefs are right or wrong, decent or indecent,²⁰⁰ it is true that the ACA did focus its most robust protection on those lower on the socioeconomic ladder, and, where a societal good is priced in such a way that many Americans have trouble paying for it, this surely can breed resentment against the law.²⁰¹ That the support of the law from those without tax subsidy insulation—those facing the worst of the market—has undoubtedly curdled, underscores the importance of rebuilding the market to better take account of the

194. Pear, *supra* note 191.

195. *Id.*

196. See Sarah Kliff, *Why Obamacare Enrollees Voted for Trump*, VOX (Dec. 13, 2016, 8:10 AM), <https://www.vox.com/science-and-health/2016/12/13/13848794/kentucky-obamacare-trump>.

197. See John C. Goodman, *Six Problems with the ACA That Aren't Going Away*, HEALTH AFF. BLOG (June 25, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150625.048781/full/> (“A family of four at 138 percent of poverty is able to enroll in Medicaid in about half the states and obtain insurance worth about \$8,000. Since the coverage is completely free, that’s an \$8,000 gift. If they earn one dollar more, they will be entitled to go into a health insurance exchange and obtain a private plan that costs, say, 50 percent more in return for an out-of-pocket premium of about \$900. That’s a gift of more than \$11,000.”).

198. Goodnough, *supra* note 39.

199. *Id.*; see also Tami Luhby, *Why So Many People Hate Obamacare*, CNN (Jan. 6, 2017, 10:45 AM), <http://money.cnn.com/2017/01/05/news/economy/why-people-hate-obamacare/index.html> (“Please show me where in the Constitution it says that the government should ‘promote the general welfare’ by stealing from half the population to give to the other half.”).

200. See Caitlin Dewey, *White America’s Racial Resentment Is the Real Impetus for Welfare Cuts*, *Study Says*, WASH. POST (May 30, 2018), <https://www.google.com/amp/s/www.washingtonpost.com/amphtml/news/wonk/wp/2018/05/30/white-americas-racial-resentment-is-the-real-impetus-for-welfare-cuts-study-says/> (“White Americans called for deeper cuts to welfare programs after viewing charts that showed they would become a racial minority within 50 years. . . . Researchers have also shown that white Americans’ racial prejudice affects their views on everything from healthcare policy to the death penalty to dogs.”).

201. In this way, the ACA played in to the 2016 presidential election in astounding ways. See generally ARLIE RUSSELL HOCHSCHILD, *STRANGERS IN THEIR OWN LAND: ANGER AND MOURNING ON THE AMERICAN RIGHT* (2016) (exploring the connection between emotional decision making and the 2016 presidential election in the United States); Jason DeParle, *Why Do People Who Need Help From the Government Hate It So Much?*, N.Y. TIMES (Sept. 19, 2016), <https://www.nytimes.com/2016/09/25/books/review/strangers-in-their-own-land-arlie-russell-hochschild.html> (“What unites her subjects is the powerful feeling that others are ‘cutting in line’ and that the federal government is supporting people on the dole—‘taking money from the workers and giving it to the idle.’ Income is flowing up, but the anger points down.”).

system's underlying costs. Additional challenges—for example, the cost of the tax-subsidy system in relation to Medicaid expansion—further highlights the need for an immediate solution to the cost problem.²⁰²

II. THE MARKET'S STRUCTURAL CONFLICTS OF INTEREST

That the ACA empowered private insurance companies to provide health insurance through the ACA exchanges—private, profit-driven, margin-obsessed private corporations with heavy government regulation and dual subsidies—reflects notable, if not curious, policy architecture, mainly because the federal government and America's private insurance companies share an immiscible conflict of interest. One has sought, prominently through the ACA, to expand access to insurance and care, whereas the other, to remain viable, has to limit access to that care. Instead of trying to protect beneficiaries by directly regulating the cost of care on the front end, and in lieu of negotiating with health insurers, the government wrote it a blank check. This structure highlights a challenge for the ACA's architecture and explains why the ACA is unable to squeeze the cost of health care.

Health insurance, by its nature, operates as a risk-spreading mechanism.²⁰³ For an insurance company to increase its profits, it has to collect more in premiums than it pays out in claims.²⁰⁴ It can accomplish this goal in one of two ways: it can either increase premiums or cut payouts, either through establishing discounts with providers and hospitals or through constricting the types of treatments and procedures it will cover. In fact, survival and success of its business model depends upon its beneficiaries *not* accessing health care—and specifically *not* accessing *expensive* health care.

This point is worth underscoring: it is not simply that health insurance plans are *ambivalent* as to whether or not their beneficiaries access health care, but insurance companies are *dependent* upon a number of their beneficiaries *not* accessing care in a given year. Their profit depends upon limiting access to care.²⁰⁵ Indeed, what made uninsured Americans unable to access health insurance before the ACA's passage—from a market perspective—was the fact that those potential beneficiaries were unprofitable for insurance companies to

202. See Susannah Luthi, *ACA Subsidies Cost More Per Person than Medicaid. Is that Sustainable?*, MOD. HEALTHCARE (Aug. 8, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180808/NEWS/180809915>.

203. See Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 437 (2010); Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1043 (1996) (“Group health insurance is less expensive to obtain and administer than individual insurance due to risk spreading and economies of scale.”).

204. See Mariner, *supra* note 203, at 446–47 (noting that insurance companies “have a financial incentive to retain as much of the premiums as possible by paying fewer benefits”).

205. See Seth D. Ginsberg, *Five Ways Insurance Companies Meddle in Your Health Care*, U.S. NEWS (July 13, 2017), <https://health.usnews.com/health-care/for-better/articles/2017-07-13/5-ways-insurance-companies-meddle-in-your-health-care> (noting that insurers can become more profitable by “limiting coverage for certain treatments and passing expenses on to customers”).

cover.²⁰⁶ Thus, the ACA had to make these beneficiaries profitable enough for insurance companies to cover them on the individual marketplace, ultimately coaxing companies to participate in the market altogether. And that is one of the reasons why the ACA was such a notable accomplishment.

A. COOPERATIVE CORPORATISM

The ACA has built a structure that is reliant on what can be called cooperative corporatism. The functionality of the market depends upon whether insurance companies—the same corporations that are required to maximize shareholder value and profits—are willing to participate and offer plans on the highly-regulated exchanges.²⁰⁷ If they want the markets to succeed, therefore, the federal government and state insurance commissioners throughout the country have little power to push insurance companies to hold down their price increases year-over-year because, of course, they are reliant on the insurance companies agreeing to continue to participate in the markets.²⁰⁸ Insufficient profits mean no market.

As a result, instead of the federal government holding leverage over insurance companies, the ACA's markets have been organized the other way around. The government becomes an involuntary partner to the price increases, having no ability to challenge them,²⁰⁹ but on the hook for funding them. Corporate appeasement, needless to say, is a disastrous cost control policy.

Additionally, in this way, the ACA's individual market functions nearly directly opposite to the way of the most efficient health care systems around the world. In other systems, most of the pricing leverage is on the side of the *government payer*, allowing the state to effectively hold down the price of health care.²¹⁰ In the United States under the ACA, however, the state has too little

206. See Gene B. Sperling & Michael Shapiro, *How the Senate's Health-Care Bill Would Cause Financial Ruin for People with Preexisting Conditions*, ATLANTIC (June 23, 2017), <https://www.theatlantic.com/business/archive/2017/06/ahca-senate-bill-preexisting-conditions/531375/> (noting that repealing the ACA would reinstall “a system in which companies often profited not by how well they provided healthcare but by how well they discriminated against or screened out those who faced the most challenges”); Jordan Weissmann, *Trump Has Brought Back the Kind of Junk Health Insurance that Obamacare Was Meant to Ban*, SLATE (Aug. 1, 2018, 5:51 PM), <https://slate.com/business/2018/08/trump-has-brought-back-the-type-of-junk-health-insurance-that-obamacare-was-meant-to-ban.html> (“Routing young, healthy insurance shoppers away from the Obamacare exchange will skew that market further towards sick, unprofitable patients, forcing carriers to raise their prices in order to make a profit.”).

207. See Shelby Livingston, *Insurers Won't Commit to 2018 Exchanges Until They Know ACA's Future*, MOD. HEALTHCARE (Feb. 3, 2017, 12:00 AM), <https://www.modernhealthcare.com/article/20170203/NEWS/170209984>.

208. See, e.g., Jim Galloway, *State Insurance Commissioner Okays Massive Premium Hikes on ACA Exchanges*, ATLANTA JOURNAL-CONSTITUTION (Sept. 28, 2017), <https://www.ajc.com/blog/politics/state-insurance-commissioner-okays-massive-premium-hikes-aca-exchanges/O19XJwHNCzYpSiCyPt1KjN/>; Paula Wissel, *Health Insurance Premiums for Individuals Could Rise by 19 Percent In Washington*, KNKX SEATTLE (June 5, 2018), <https://www.knkx.org/post/health-insurance-premiums-individuals-could-rise-19-percent-washington>.

209. *Id.*

210. See Jerome Groopman & Pamela Hartzband, *Putting Profits Ahead of Patients*, N.Y. REV. BOOKS (July 13, 2017), <http://www.nybooks.com/articles/2017/07/13/putting-profits-ahead-of-patients/> (“Many

leverage in its attempts to ensure insurance companies participate in the markets²¹¹—to say nothing of its ability to impact the *pricing* of those plans.²¹²

B. SYMBIOTIC PRICING

Called “arguably one of the most effective tools the White House has to hold down premium costs,” and the “Obamacare provision that terrifies insurers,”²¹³ the Medical Loss Ratio (MLR) within the ACA was gloriously hailed as an indispensable policy tool that would ensure that “consumers [were] receiving a higher return on their premium dollars.”²¹⁴ Writing in 2011 before *NFIB*, it was also asserted that it would “ultimately, lead to the death of large parts of the private, for-profit health insurance industry.”²¹⁵ Housed within the sprawling ACA,²¹⁶ the MLR was intended to “limit supposedly wasteful and self-serving spending by insurers.”²¹⁷ Specifically, the MLR works by limiting “the portion of premium dollars health insurers may spend on administration, marketing, and profits,”²¹⁸ and mandating that “insurers must spend at least 80

industrialized nations, including Germany, Japan, Belgium, and others, have uniform negotiated national fee schedules for hospital admissions and clinical encounters with doctors.”); Katie Thomas, *The Fight Trump Faces over Drug Prices*, N.Y. TIMES (Jan. 23, 2017), <https://www.nytimes.com/2017/01/23/health/the-fight-trump-faces-over-drug-prices.html> (noting that Canada and Britain have systems that feature “leverage with many multinational drug corporations” and that “[t]heir government-run health programs are the only game in town and hold significant power in setting drug prices.”); see also *Why Is Health Care So Expensive?*, CONSUMER REP. (Sept. 2014) <https://www.consumerreports.org/cro/magazine/2014/11/it-is-time-to-get-mad-about-the-outrageous-cost-of-health-care/index.htm> (stating that Medicare “is by far the largest single source of revenue for most health care providers, which gives it more leverage to set prices.”).

211. See Olga Khazan, *Why So Many Insurers Are Leaving Obamacare*, ATLANTIC (May 11, 2017), <https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/>.

212. See Holly Fletcher, *Tennessee Insurance Commissioner: Obamacare Exchange “Very Near Collapse,”* TENNESSEAN (Aug. 23, 2016), <https://www.tennessean.com/story/money/industries/health-care/2016/08/23/insurers-get-approval-for-2017-obamacare-rates/89196762/> (noting that the Tennessee Insurance Commissioner signed off on rate increases of 62%, 46%, and 44% respectively, for the health insurance exchange in 2017, largely because “[t]he rate approvals . . . were necessary to ensure healthcare options in every part of Tennessee when open enrollment beg[an] in November”).

213. Sarah Kliff, *The Obamacare Provision That Terrifies Insurers*, WASH. POST (July 18, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/07/18/the-obamacare-provision-that-terrifies-insurers/?utm_term=.c3052c24840b.

214. David Hudson, *The “80/20 Rule” Is Saving Americans a Lot of Money. But What Exactly Is It?*, WHITE HOUSE BLOG (July 24, 2014, 3:39 PM), <https://obamawhitehouse.archives.gov/blog/2014/07/24/8020-rule-saving-americans-lot-money-what-exactly-it>.

215. Rick Ungar, *The Bomb Buried in Obamacare Explodes Today—Hallelujah!*, FORBES (Dec. 2, 2011, 3:44 PM), <https://www.forbes.com/sites/rickungar/2011/12/02/the-bomb-buried-in-obamacare-explodes-today-halleluja/#cf9c0a4fab6>.

216. See 42 U.S.C. § 300gg-18 (2018); 45 C.F.R. § 158.210 (2019) (referring to “[m]inimum medical loss ratio”).

217. Sally Pipes, *HHS Can Target Obamacare’s Medical Loss Ratio Rule Right Away*, FORBES (Apr. 17, 2017, 8:00 AM), <https://www.forbes.com/sites/sallypipes/2017/04/17/hhs-can-target-obamacares-medical-loss-ratio-rule-right-away/#b7a850973220>.

218. *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, *supra* note 113.

percent of their premium revenue on medical care and quality improvement.”²¹⁹ For large-group insurers, the companies must spend at least 85%.²²⁰

The remaining 20% (or 15% for large-group insurers)²²¹ of each dollar collected via premiums can be allocated to “pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions.”²²² Insurance companies that miss the required MLR must provide rebates to its beneficiaries.²²³ Due to its importance, a battle front quickly opened between insurance companies and regulators over how to appropriately define what counted as a medical or quality improvement service.²²⁴

There is no doubt that the MLR saved American beneficiaries a lot of money. According to the Obama White House, the MLR prevented consumers from paying what would have amounted to an estimated additional \$9 billion in premiums from 2011 to 2013.²²⁵ Even after the markets were fully functioning, it has continued to save beneficiaries money. According to Kaiser, in 2015, a total of nearly 1.2 million beneficiaries received MLR rebates totaling \$107.3 million.²²⁶ The regulatory floor that the ACA’s MLR provision imposed undoubtedly improved the financial efficiency of health insurance.²²⁷

But, while it limits what health insurers can charge, it does not limit overall price increases. Indeed, mandating a certain level of efficiency for health insurers and reducing the overall cost of American health care are two separate aims. The MLR, while noble in its goals and “relatively easy” to understand in terms of its vague cost control intentions,²²⁸ ensures that the premiums American beneficiaries pay are more tightly tied to the cost of their health care. But the MLR does nothing to hold down the cost of their health care at the outset.

Worse, the MLR may not only be neutral on the cost control question, but, stunningly, may actually *harm* global cost control efforts, blunting the natural incentive of insurance companies to strenuously negotiate with providers and hospitals in efforts to hold down the costs of health care. Under an MLR, a health

219. Julie Appleby, *Final Medical Loss Ratio Rule Rebuffs Insurance Agents*, KAISER HEALTH NEWS (Dec. 2, 2011), <https://khn.org/news/final-medical-loss-ratio-rule-rebuffs-insurance-agents/>.

220. *Id.*

221. *See id.*

222. *Medical Loss Ratio (MLR)*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/> (last visited Jan. 24, 2020).

223. *See Medical Loss Ratio*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html> (last visited Jan. 24, 2020).

224. *The Gaming Begins*, N.Y. TIMES (May 23, 2010), <https://www.nytimes.com/2010/05/24/opinion/24mon2.html>.

225. *See* Hudson, *supra* note 214.

226. *See Medical Loss Ratio (MLR) Rebates in the Individual Market for Consumers and Families*, KAISER FAM. FOUND., <https://www.kff.org/health-reform/state-indicator/mlr-rebates-individual-market/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last updated Nov. 15, 2018).

227. *See* Kliff, *supra* note 213 (noting that, prior to the ACA MLR, some individual health insurance plans “would spend as little as 60 percent on medical costs”).

228. *Id.*

insurance company—the only actor in the health care delivery system that is purportedly incentivized to hold down the cost of health care—actually *hurts itself more* by vigorously holding down price increases because its profits are limited to a percentage of premiums collected. Lower health care prices lead to smaller profits. No matter how you slice it, 20% of a smaller pie is a smaller number.

Put another way, an insurance company that wishes to grow its profit—not the *percentage* of profit it is allowed to pocket in the marketplaces, but the gross amount of profit—is *incentivized* to raise its premiums. Because there is no limit on the amount premiums can increase on an annual basis, there is a limit on the percentage of profit an insurance company can pocket. There is a simple solution for the insurance company seeking to grow its profits: raise prices, or, at least avoid spirited negotiations with health systems and providers in which the insurance company seeks to limit cost growth in the system. In effect, then, the MLR blunts the most powerful cost control impulses of the insurance companies, whose officers, by the way, have fiduciary duties to maximize company profits for their shareholders.²²⁹

There is a clear response to this concern: in the private marketplace, insurance companies that fail to hold down premium increases effectively will lose customers. And, like in any private marketplace, those insurance companies that can limit their year-over-year premium increases will be rewarded in the individual marketplace by growing market share. After all, no one wants to pay for a health insurance plan that inadequately negotiates with providers; as a result, those insurance plans that inflate prices (or allow their prices to grow) in an effort to increase their profits will be damaged when consumers flee their plans because of the cost of their premiums.

But that response ignores three important details about the health insurance marketplace that all demonstrate that it is unlike any other typical market. Specifically, (1) the health insurance market is under-competitive; (2) the health insurance consumer is not price-sensitive; and (3) increasingly saturated health-care provider markets have already flipped leverage in the provider-insurer relationship. Relying on the consumer to prevent the worst excesses of the ACA private exchange market is ineffective.

Like an annual ritual, substantial hand wringing has occurred around the concern that whole counties will soon lack an ACA exchange insurer.²³⁰ Even though it has not yet happened,²³¹ the number of counties with just one

229. See ELISABETH ROSENTHAL, AN AMERICAN SICKNESS: HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK 18 (2017) (“WellPoint’s first priority appear[ed] no longer to be its patient/members or even the companies and unions that [chose] it as an insurer, but instead its shareholders and investors.”).

230. See Haeyoun Park & Audrey Carlsen, *For the First Time, 45 Counties Could Have No Insurer in the Obamacare Marketplaces*, N.Y. TIMES (June 9, 2017), <https://www.nytimes.com/interactive/2017/06/09/us/counties-with-one-or-no-obamacare-insurer.html>.

231. See Dylan Scott, *There Are No More Counties Without Any Obamacare Plans*, VOX (Aug. 24, 2017, 4:20 PM), <https://www.vox.com/health-care/2017/8/24/16199620/voxcare-no-counties-without-obamacare>.

participating insurer has been striking.²³² In fact, in 2018, a majority of counties in the individual marketplace (52% of all counties)—nonetheless representing where about 26% of enrollees live—had one participating insurer on the ACA marketplace.²³³ This percentage is lower than originally projected,²³⁴ but a marketplace with only one participating insurer is not a competitive marketplace. A sole competitive insurer can raise prices with impunity. Given anemic competition, any “profit-share penalty” for raising premiums—a typical deterrent for sellers in other marketplaces—is severely blunted.

In addition to insurance companies’ failure to represent a typical seller’s market, beneficiaries shopping for an individual health insurance plan are not true consumers in any typical sense.²³⁵ Again, the majority of beneficiaries receive subsidies that cover the majority of their health insurance costs,²³⁶ weakening their drive to be price-discriminating consumers. Whether or not beneficiaries have enough “skin in the game” is a topic that has garnered scholarly attention.²³⁷ However, notwithstanding the perfect calibration of consumer “pain,” any subsidy that helps the many beneficiaries purchasing plans on the ACA individual market lessens the pressure on beneficiaries to be naturally price-discriminating. A consumer who enjoys the fact that more than 80% of one’s bill is being covered by the federal government cannot possibly mimic a true consumer.

Finally, insurance companies that do not strenuously negotiate, while being more attractive to providers and hospitals, may also—as a byproduct of being weaker negotiators—actually make their products more attractive by offering larger networks to the beneficiaries who sign up for their plans. If the insurance company is less concerned about aggressively having to attract customers to purchase its plan while also being more dependent on premium assistance tax credits from the federal government, it is less worried about holding down its prices, which makes it *more* attractive to hospitals and doctors who wish to increase their prices. In this way, the MLR within the ACA may actually be *incentivizing insurance companies to allow providers and hospitals to raise prices* faster than they otherwise would.

232. See Ashley Semanskee et al., *Insurer Participation on ACA Marketplaces, 2014–2018*, KAISER FAM. FOUND. (Nov. 10, 2017), <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/2881/>.

233. See *id.* (showing that the entire states of Kentucky, Delaware, Alaska, South Carolina, Oklahoma, Iowa, Mississippi, Nebraska, Arizona, and Wyoming, and a clear majority of counties in Missouri, North Carolina, Georgia, Alabama, Tennessee, and North Dakota had only one insurer in 2018).

234. See Khazan, *supra* note 211 (“The fact that one-third of counties are projected to have just one insurer on their Obamacare exchanges this year has been a popular talking point among Republicans—including President Trump—trying to gin up support for their replacement bill, the American Health Care Act.”).

235. See Paul Krugman, *Patients Are Not Consumers*, N.Y. TIMES (Apr. 21, 2011), <https://www.nytimes.com/2011/04/22/opinion/22krugman.html> (“The idea that all this can be reduced to money—that doctors are just ‘providers’ selling services to health care ‘consumers’—is, well, sickening.”).

236. See *supra* notes 146–147 and accompanying text.

237. See, e.g., Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921 (2013).

C. POLITICAL AND REGULATORY DEGRADATION

In an easy jump, financial pain, socioeconomic chafing, and unbridled resentment can very easily slide into political degradation. The truth is the ACA has not enjoyed clear public support since its implementation. This, among other characteristics, has been a particularly troublesome feature of a law that many policy experts thought would be popular.²³⁸ That it took a direct frontal assault in early 2017 to finally pull the law over 50 percent approval should be telling.²³⁹ Unsurprisingly, polling on removing the individual mandate penalty was split nearly completely in half in early 2017.²⁴⁰ This, of course, has continued to place its long-term stability at risk, and has led Republicans to strive to repeal president Obama's signature piece of legislation for the better part of a decade.²⁴¹

This resentment is not without political costs.²⁴² Reporting after the 2016 election, Sarah Kliff found that “[m]any expressed frustration that Obamacare plans cost way too much, that premiums and deductibles had spiraled out of control. And part of their anger was wrapped up in the idea that other people were getting even better, even cheaper benefits—and those other people did not deserve the help.”²⁴³

The law is not threatened only by political degradation, but also regulatory degradation. The government's decision to link the expansion in access to an expansion and reordering of the private insurance marketplace creates a regulatory conflict of interest. Because the government is *both* committed to expanding the number of individuals who have insurance *and* responsible for

238. See Ezra Klein, *Obamacare's Most Popular Provisions Are Its Least Well Known*, WASH. POST (Mar. 22, 2013, 10:01 AM), https://www.washingtonpost.com/news/wonk/wp/2013/03/22/obamacares-most-popular-provisions-are-its-least-well-known/?utm_term=.9a208d0c79f8 (“The argument of Obamacare's advocates has always been that it will become more popular in 2014, when it begins rolling out its benefits. . . . But pressing against that prediction is the fact that it will also become less popular as implementation leads to lots of stories about where the law is failing and what it could be doing better.”).

239. See Norman, *supra* note 28.

240. See Jennifer Agiesta, *CNN/ORC Poll: Public Splits on Revoking Individual Mandate*, CNN (Mar. 7, 2017, 7:31 AM), <https://www.cnn.com/2017/03/07/politics/health-care-replacement-poll/index.html>.

241. See Juliet Eilperin et al., *Senate Republicans' Effort to "Repeal and Replace" Obamacare All But Collapses*, WASH. POST (July 18, 2017), https://www.washingtonpost.com/powerpost/trump-suggests-republicans-will-let-aca-market-collapse-then-rewrite-health-law/2017/07/18/5e79a3ec-6bac-11e7-b9e2-2056e768a7e5_story.html?utm_term=.afd8438f3baf (noting a “seven-year quest” to repeal the law).

242. See Sarah Kliff, *Why Obamacare Enrollees Voted for Trump*, VOX (Dec. 13, 2016, 8:10 AM), <https://www.vox.com/science-and-health/2016/12/13/13848794/kentucky-obamacare-trump>. On this point, one of the individuals Kliff spoke to in Kentucky said the following:

“They can go to the emergency room for a headache,” she says. “They’re going to the doctor for pills, and that’s what they’re on.” She felt like this happened a lot to her: that she and her husband have worked most their lives but don’t seem to get nearly as much help as the poorer people she knows. She told a story about when she used to work as a school secretary: “They had a Christmas program. Some of the area programs would talk to teachers, and ask for a list of their poorest kids and get them clothes and toys and stuff. They’re not the ones who need help. They’re the ones getting the welfare and food stamps. I’m the one who is the working poor.”

Id.

243. *Id.*

regulating—and theoretically, penalizing—insurance plans that deviate from the strictures of the ACA’s rules, it may be the case that one interest inextricably conflicts with the other. For instance, if the government’s interest in adequately policing the individual exchange marketplace shrinks the number of plans for sale on those exchanges, it ultimately harms its goal in achieving universal coverage through supporting and protecting robust marketplaces.

III. TEN YEARS OF BEHAVIORAL ECONOMICS

Ten years after its original insights,²⁴⁴ behavioral economics has surely come to the law—even health law.²⁴⁵ A field credited to Cass Sunstein and Richard Thaler,²⁴⁶ behavior economics study has been described as “economics done with strong injections of good psychology.”²⁴⁷ The field’s “core insight” lays on the realization that “human beings do not always act in [their] own long-term best interests,”²⁴⁸ and that individuals “have limited cognitive abilities and a great deal of trouble exercising self-control.”²⁴⁹ Further, people are “profoundly influenced by context, and often have little idea of what they will prefer next year or even tomorrow.”²⁵⁰ These insights encourage choice architects and policymakers to consider the construction of various “nudges,” which are intended to encourage decision-makers to make better “prosocial” decisions.²⁵¹

The contributions of Sunstein and Thaler are evidenced by their bestselling book,²⁵² *Nudge*, published in 2008.²⁵³ These insights have been used to influence law and policy development, seeking to build structures that lead to better individual decision-making and, ultimately, better policy outcomes, without legal compulsion. As such, the field of behavioral economics has been an

244. See *Nudge Turns 10: A Special Issue on Behavioral Science in Public Policy*, BEHAV. SCIENTIST (Sept. 4, 2018), <http://behavioralscientist.org/nudge-turns-10-a-special-issue-on-behavioral-science-in-public-policy/> (“Since 2008, these units, and researchers and policymakers with an eye for applying behavioral science in government, have influenced everything from tax policy to retirement savings, from energy consumption to environmental responsibility.”).

245. See, e.g., NUDGING HEALTH: HEALTH LAW AND BEHAVIORAL ECONOMICS (I. Glenn Cohen et al. eds., 2016) [hereinafter NUDGING HEALTH] (offering an overview of behavioral science in health law).

246. Thaler won the Nobel prize in 2017 for his work on behavioral economics. See David Halpern, “Behavioural Economics” May Sound Dry— But It Can Change Your Life, GUARDIAN (Oct. 10, 2017, 11:23 AM), <https://www.theguardian.com/commentisfree/2017/oct/10/behavioural-economics-richard-thaler-nudge-nobel-prize-winner>.

247. David Gal, *Why Is Behavioral Economics So Popular?*, N.Y. TIMES (Oct. 6, 2018), <https://www.nytimes.com/2018/10/06/opinion/sunday/behavioral-economics.html>.

248. Jessica L. Roberts, *Nudge-Proof: Distributive Justice and the Ethics of Nudging*, 116 MICH. L. REV. 1045 (2018) (observing distributional concerns caused by the practice of “nudging”).

249. Shahram Heshmat, *What Is Behavioral Economics?*, PSYCHOL. TODAY (May 3, 2017), <https://www.psychologytoday.com/us/blog/science-choice/201705/what-is-behavioral-economics>.

250. *Id.*

251. Roberts, *supra* note 248, at 1047.

252. See *Nudge: Improving Decisions About Health, Wealth, and Happiness*, GOODREADS, <https://www.goodreads.com/book/show/3450744-nudge> (last visited Jan. 24, 2020).

253. See RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

important tool in recent discourse surrounding the future of legal regulation. One contribution of Sunstein and Thaler that has been particularly influential has been their work around libertarian paternalism.²⁵⁴

Drawing on some well-established findings in behavioral economics and cognitive psychology, we emphasize the possibility that in some cases individuals make inferior decisions in terms of their own welfare—decisions that they would change if they had complete information, unlimited cognitive abilities, and no lack of self-control. . . . Libertarian paternalism is a relatively weak and nonintrusive type of paternalism, because choices are not blocked or fenced off. In its most cautious forms, libertarian paternalism imposes trivial costs on those who seek to depart from the planner's preferred option. But the approach we recommend nonetheless counts as paternalistic, because private and public planners are not trying to track people's anticipated choices, but are self-consciously attempting to move people in welfare-promoting directions.²⁵⁵

Recent writing has suggested that individuals prefer such “nudges” that rely on “statistical information and factual disclosures” largely “on the assumption that they show greater respect for individual autonomy and dignity and promote individual agency” more than nudges that are not “educative and which target or benefit from automatic processing.”²⁵⁶

Nonetheless, the insights made by Sunstein and Thaler have been imported into health law and policy, as “[p]eople often make decisions in health care that are not in their best interest.”²⁵⁷ Expanding horizons beyond traditional hard law tools, health policy and public health experts have increasingly explored and deployed softer incentives based on new understandings of human behavior.²⁵⁸ These efforts may either reward actors who advance public aims, penalize those who fail to achieve them, or—more simply—seek to improve decision-making from independent actors. One of the upsides of these softer regulatory interventions is the avoidance of command and control mandates from the state.

A. MODERN POLICY “NUDGES” IN HEALTH LAW

Drawing on lessons in other areas of health law that have adopted more targeted interventions, the ACA's individual marketplace could be more intentional about health care “nudges.”²⁵⁹ Indeed, as currently constructed, health insurance companies are not encouraged to think about the long-term impacts of rising premiums, nor are they incentivized to undertake cost-saving efforts that are directly contradictory to their profit goals. Recent examples of

254. See Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1162 (2003).

255. *Id.* (footnotes omitted).

256. Cass R. Sunstein, *People Prefer System 2 Nudges (Kind of)*, 66 DUKE L.J. 121, 123 (2016).

257. Thomas Rice, *The Behavioral Economics of Health and Health Care*, 34 ANN. REV. PUB. HEALTH 431, 431–32 (2013) (“Indeed, many of the most vexing problems facing individuals and society as a whole in health care are neither medical nor scientific in nature; they are behavioral.”).

258. See NUDGING HEALTH, *supra* note 245.

259. See Alan M. Garber, *Can Behavioral Economics Save Healthcare Reform?*, in NUDGING HEALTH, *supra* note 245, at 27.

the increasing deployment of tools from behavioral economics within health law and policy—soft pressures that encourage particularized decision-making, or push decision-makers to just be more deliberative—are illustrative.

1. *Consumers and Employees: Soft Efforts*

Soft efforts that seek to improve individual decision-making can be found prominently in the public health sphere. A legitimate primary policy goal of a state—a healthier populace—leads to policymaking that seeks to encourage citizens to make healthier decisions.²⁶⁰ But by employing science on decision-making, the interventions can be constructed in a way that make the population more likely to choose the healthier option without deploying mandates. One of the chief challenges, of course, associated with employing these interventions is avoiding causing a backlash due to their coercive nature, something that has been common in health law and policy.²⁶¹ Indeed, mandates engender opposition.²⁶²

Constructed with the important goal of encouraging citizens or employers to make healthier decisions, recent examples of health interventions include restaurant calorie counts, employer wellness bonuses, and city soda taxes. While these interventions may have some of the hallmarks of a hard mandate, they do not interfere with the ultimate actor's ability to make a decision. Instead, these interventions seek to change incentives for the decision-makers, pushing, or nudging, them to make decisions that result in better health outcomes, while also producing monetary savings for the employer or city. For sure, their overall effectiveness is not assured because they still are dependent upon the end user's decision.

In fact, their general effectiveness is still debated. Notably, how interventions are framed, whether as a gain or loss, have been shown to not make a difference in behavior.²⁶³ Nonetheless, it appears that imposing penalties for undesirable behavior—an example of which would be soda taxes—may be more effective than the information-ensuring calorie counts or voluntary employer wellness incentives. Each is summarized in turn below.

Calorie Counts. In the spirit of providing more information to consumers,²⁶⁴ and required by the ACA for restaurants with twenty or more

260. See, e.g., Jennifer L. Matjasko et al., *Applying Behavioral Economics to Public Health Policy*, 50 AM. J. PREVENTIVE MED. S13, S13 (2016).

261. See Garber, *supra* note 259, at 35–36.

262. See Margot Sanger-Katz, *Obamacare's Insurance Mandate Is Unpopular. So Why Not Just Get Rid of It?*, N.Y. TIMES (Nov. 14, 2017), <https://www.nytimes.com/2017/11/14/upshot/obamacares-insurance-mandate-is-unpopular-so-why-not-just-get-rid-of-it.html> (“In a bill with many unloved parts, the Affordable Care Act’s individual mandate has long been the most loathed.”); see also Zachary Tracer, *The Individual Mandate*, BLOOMBERG (Dec. 22, 2017, 12:52 PM), <https://www.bloomberg.com/quicktake/individual-mandate> (noting the mandate as the “least popular part of the Affordable Care Act”).

263. See Gal, *supra* note 247.

264. See Maggie Fox, *Restaurant Menu Label Rules Go into Effect*, NBC NEWS, <https://www.nbcnews.com/health/health-news/restaurant-menu-label-rules-go-effect-n872066> (last updated May 8, 2018, 7:39 PM).

locations,²⁶⁵ publishing menu calorie counts seeks to push consumers to make healthier choices in restaurants.²⁶⁶ But because they are voluntarily employed by consumers, and there are no immediately ascertainable impacts for relying on them or not in making decisions, their effectiveness may be limited. Past experiences have been illuminating.

After New York City deployed the counts, customers “reported that they saw and used calorie counts more often than people did in restaurants without labels,” but, as the years wore on, “fewer and fewer people reported noticing them or considering them,” and eventually ignored them.²⁶⁷ Other studies have concluded that although individuals noticed the counts and they resulted in “increased nutrition information awareness,” it did not ultimately change ordering decisions.²⁶⁸ Another systematic review concluded that “over all, menu labeling did not produce any significant changes in what people ordered.”²⁶⁹

Employer Wellness Programs. Employer wellness programs reward employees—typically financially—who adopt healthier behaviors and/or make healthier decisions.²⁷⁰ Reports on whether they are successful are also mixed.²⁷¹ Although it seems as though financial incentives would impact decision-making, one recent study concluded that employees’ behaviors do not improve, and employers do not achieve cost savings, as a result of such a program.²⁷² Nonetheless, another study “found 25 percent lower sick leave, health plan, workers’ compensation, and disability insurance costs among companies that had wellness programs.”²⁷³

Still another study “found an average annual health care cost increase of 1–2% for companies with wellness programs, compared to the 7% national

265. *Id.*

266. See Aaron E. Carroll, *The Failure of Calorie Counts on Menus*, N.Y. TIMES (Nov. 30, 2015), <https://www.nytimes.com/2015/12/01/upshot/more-menus-have-calorie-labeling-but-obesity-rate-remains-high.html>.

267. *Id.*

268. *Id.*

269. *Id.*

270. See Darla Mercado, *It May Sound Crazy, but Employees Are Leaving Money on the Table at Work*, CNBC, <https://www.cnbc.com/2018/11/28/why-youre-leaving-money-on-the-table-at-work.html> (last updated Nov. 28, 2018, 3:35 PM), (noting that wellness programs enable the employee to earn small bonuses for signing up and fulfilling the challenge); see also *Kaiser Offers Cash Bonuses in Employee Wellness Program*, BECKER’S HOSP. REV. (Sept. 20, 2013), <https://www.beckershospitalreview.com/human-capital-and-risk/kaiser-offers-cash-bonuses-in-employee-wellness-program.html> (“Kaiser Permanente and the 29 unions representing its employees are offering up to \$500 bonuses to groups of workers who lose weight, lower their blood pressure, stop smoking and lower their cholesterol levels.”).

271. See Aaron E. Carroll, *Workplace Wellness Programs Don’t Work Well. Why Some Studies Show Otherwise*, N.Y. TIMES (Aug. 6, 2018), <https://www.nytimes.com/2018/08/06/upshot/employer-wellness-programs-randomized-trials.html> (noting the limitations and challenges involved in observational studies that review the effectiveness of wellness programs).

272. See Rebecca Greenfield, *Workplace Wellness Programs Really Don’t Work*, BLOOMBERG (Jan. 26, 2018), <https://www.bloomberg.com/news/articles/2018-01-26/workplace-wellness-programs-really-don-t-work> (“Their study found that wellness programs—even those with incentives—don’t change employees’ behavior much.”).

273. Holly Lebowitz Rossi, *5 Hallmarks of Successful Corporate Wellness Programs*, FORTUNE (Apr. 13, 2015), <http://fortune.com/2015/04/13/corporate-wellness/>.

average.”²⁷⁴ Observational studies on such programs demonstrate that wellness programs can be plagued with limited value.²⁷⁵ Notwithstanding the effectiveness of the wellness programs, they are increasingly popular across the country.²⁷⁶

Soda Taxes. Soda taxes have also proliferated across the United States, including a prominent and successful soda tax deployed by the city of Philadelphia.²⁷⁷ Upheld by the Pennsylvania Supreme Court in 2018,²⁷⁸ Philadelphia’s soda taxes—which impose a 1.5 cent per ounce tax on sweetened beverages—have succeeded in shrinking soda consumption rates.²⁷⁹ Early studies have shown that “Philadelphians are about 40 percent less likely than residents of three nearby cities to have a soda every day.”²⁸⁰ In addition to positive health impacts, the tax funds a pre-kindergarten program in the city.²⁸¹ And it has enjoyed popular support: in late 2016, three months before the tax took effect, 54% of Philadelphia’s residents polled supported the tax, with 42% opposed.²⁸²

But reports from Philadelphia have not been all positive. Critics have suggested that the city is not raising as much revenue as anticipated,²⁸³ as revenue from the program pulled in about \$80 million for the city in its first year.²⁸⁴ In another example, Chicago repealed its soda tax after it generated

274. *Id.*

275. See Carroll, *supra* note 266.

276. See Kerry Hannon, *Why Workplace Financial Wellness Programs Are Hot*, FORBES (May 18, 2017, 11:00 AM), <https://www.forbes.com/sites/nextavenue/2017/05/18/why-workplace-financial-wellness-programs-are-hot/#410e432813f8> (noting the increasing percentage of employers utilizing wellness benefits).

277. See Claire Sasko, *The Soda Tax Has Had a Huge Impact on Philly’s Soda-Drinking Habits, Suggests New Study*, PHILA. MAG. (Apr. 13, 2018, 10:12 AM), <https://www.phillymag.com/news/2018/04/13/philadelphia-soda-tax-people-drinking-less-soda/> (noting the tax has “significantly decreased soda consumption in the city”).

278. See John Bacon, *Push for Soda Taxes Across USA Notches Win in Philly*, USA TODAY, <https://www.usatoday.com/story/news/nation/2018/07/18/philly-soda-tax-survives-court-challenge/796104002/> (last updated July 18, 2018, 5:54 PM).

279. See Sasko, *supra* note 277 (“Here are the conclusions . . . ‘Within the first 2 months of tax implementation, relative to the comparison cities, in Philadelphia the odds of daily consumption of regular soda was 40% lower; energy drink was 64% lower; bottled water was 58% higher; and the 30-day regular soda consumption frequency was 38% lower.’”).

280. Alan Mozes, *Philly’s Soda Tax Is Working, Study Finds*, WEBMD (Apr. 12, 2018), <https://www.webmd.com/diet/news/20180412/phillys-soda-tax-is-working-study-finds#1>.

281. See Justin Udo, *Soda Tax Dollars Finally Freed Up for Kenney’s Big Pre-K Push*, KYW NEWSRADIO (Aug. 2, 2018, 5:05 PM), <https://kywnewsradio.radio.com/articles/news/soda-tax-dollars-finally-freed-mayor-jim-kenneys-free-pre-k-initiative>.

282. See Larry Eichel, *Pew Poll Shows Philadelphians Feeling Good About Their City*, PEW (Oct. 5, 2016), <https://www.pewtrusts.org/en/research-and-analysis/articles/2016/10/05/pew-poll-shows-philadelphians-feeling-good-about-their-city>.

283. See Angelica LaVito, *Philadelphia’s Soda Tax Isn’t the Windfall Some Had Hoped for*, CNBC, <https://www.cnbc.com/2017/08/22/philadelphias-soda-tax-isnt-the-windfall-some-had-hoped-for.html> (last updated Aug. 23, 2017, 4:37 PM) (noting that the tax revenue was \$39 million, short of the projection of \$46 million).

284. See Alison Burdo, *First Full Year of Soda Tax Revenue Puts City \$13M+ Short of Goal*, PHILA. BUS. J. (Jan. 26, 2018, 8:23 AM), <https://www.bizjournals.com/philadelphia/news/2018/01/26/philly-beverage-tax->

significant controversy.²⁸⁵ Further, the target of food taxes may be broadening. Other penalties that seek to limit consumption of unhealthy foods and environmental harm—like “meat taxes”—may be on the horizon.²⁸⁶

2. Organizations and Physicians: Value Payments

The Medicare Shared Savings Program (MSSP), a voluntary incentive-based reimbursement program, is a component part of the ACA.²⁸⁷ This program seeks to reward care administered that is reflective of high quality, highly efficient care.²⁸⁸ Most basically, “the MSSP enables provider organizations to share a percentage of the savings they achieve in delivering services to Medicare beneficiaries, provided they meet quality performance standards.”²⁸⁹ This is accomplished through pushing providers and entities into creating new Accountable Care Organizations (ACOs), where the new organization is “held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.”²⁹⁰ Coordinating care in this way is intended to push providers to be more cognizant of the cost of certain care delivery, while, at the same time, improving quality by “avoiding unnecessary duplication” and “preventing medical errors.”²⁹¹

These new payment structures flip the old incentives of fee-for-service medicine on their heads, enticing organizations to deliver care that is high-quality and efficient.²⁹² After all, if the ACO achieves quality and efficiency benchmarks, “the ACO will share in the savings it achieves for the Medicare

soda-tax-pbt-2017-year-revenue.html (noting that the yield from December 2017 was an uptick from the previous month, and the city pulled in about \$80 million in the first twelve months of the program).

285. See Bernard Ellouk, *Seattle's New Tax on Sugary Drinks Kicks in Jan. 1*, KING 5 NEWS (Dec. 29, 2017, 7:05 PM), <https://www.king5.com/article/news/local/seattle/seattles-new-tax-on-sugary-drinks-kicks-in-jan-1/281-501869514>.

286. See James Hamblin, *Here Comes the Meat Tax*, ATLANTIC (Dec. 15, 2017), <https://www.theatlantic.com/health/archive/2017/12/should-meat-cost-more-than-gold/548264/>.

287. See Michael J. Montgomery, Note, *Coordination or Consolidation? Accountable Care Organizations and Antitrust Policy Under the Medicare Shared Savings Program*, 67 HASTINGS L.J. 1119, 1121–22 (2016) (“By offering financial incentives to cut costs and achieve quality benchmarks in the treatment of Medicare beneficiaries, ACOs under the MSSP promote provider accountability and move health care payment and delivery toward a more cost-efficient model that provides higher quality care.”).

288. See Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 3 (2014).

289. *Id.* at 4.

290. *About the Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html> (last updated June 3, 2019, 12:27 PM).

291. *Accountable Care Organizations (ACOs)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html> (last updated Mar. 8, 2019, 2:48 PM).

292. See Alan L. Hillman, Commentary, *Managing the Physician: Rules Versus Incentives*, 10 HEALTH AFF. 138, 138 (1991), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.10.4.138>.

program.”²⁹³ This would reverse years of incentives that encourage providers to increase billing.²⁹⁴

Early reports regarding their effectiveness were mixed.²⁹⁵ More recent reports raised the likelihood of prospective turbulence for the program, with many ACOs considering leaving the program,²⁹⁶ and proposed CMS changes to the ACO structure potentially on the horizon.²⁹⁷ Nonetheless, some of the changes may not ultimately impact ACO participation.²⁹⁸

A larger goal of the program is its hope to “leverage[e] Medicare policy to transform health delivery and payment practices in the private sector.”²⁹⁹ Mirroring the value-based movement, Medicare—through the MSSP—is seeking to incentivize hospitals to administer services that are more beneficial to both its beneficiaries and the fiscal health of the program itself.³⁰⁰ In this way, the structural frame has been constructed to push entities and providers to care more about efficiencies and quality metrics—something that previously, in the Medicare program, has been an underappreciated concern.³⁰¹

Value-based purchasing has also come to Medicare Part B.³⁰² Under the Merit-Based Incentive Payment System (MIPS), which was created under the Medicare Access and CHIP Reauthorization Act of 2015,³⁰³ physicians who participate in Medicare Part B and who are not enrolled in an alternative

293. *Accountable Care Organizations (ACOs)*, *supra* note 291.

294. See Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 542 (2013).

295. See David Muhlestein, *Medicare ACOs: Mixed Initial Results and Cautious Optimism*, HEALTH AFF. BLOG (Feb. 4, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20140204.036921/full/> (“Of the 114 ACOs in the program, only 54 of the ACOs saved money and only 29 of those saved enough money to receive bonus payments.”).

296. See Virgil Dickson, *Heading for the Exit: Rather than Face Risk, Many ACOs Could Leave*, MOD. HEALTHCARE (May 12, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180512/NEWS/180519966>.

297. See Susan Morse, *Lawmakers Ask CMS to Reconsider ACO MSSP Overhaul*, HEALTHCARE FIN. NEWS (Oct. 25, 2018), <https://www.healthcarefinancenews.com/news/lawmakers-ask-cms-reconsider-aco-mssp-overhaul>.

298. See Virgil Dickson, *ACOs to Stay in Shared-Savings Program Despite Downside Risk*, MOD. HEALTHCARE (Oct. 17, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20181017/TRANSFORMATION04/181019904>.

299. Greaney, *supra* note 288, at 4.

300. See Robert Mechanic & Clifton Gaus, *Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth*, HEALTH AFF. BLOG (Sept. 11, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180906.711463/full/> (“According to CMS, MSSP ACOs saved \$1.1 billion in 2017, with net savings of \$314 million after accounting for shared savings payments earned by ACOs.”).

301. See Bagley, *supra* note 294, at 542 (noting that the Sustainable Growth Rate formula (SGR) that did not effectively pressure physicians to care about cost “has proven ineffective”).

302. See MEDICARE SHARED SAVINGS PROGRAM IN THE QUALITY PAYMENT PROGRAM, CTRS. FOR MEDICARE & MEDICAID SERVS. (2016), <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/191/APMs-in-The-Quality-Payment-Program-for-Shared-Savings-Program-SSP-webinar-slides.pdf>.

303. See *What's MACRA*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html> (last updated June 14, 2019, 8:19 AM).

payment model (APM)³⁰⁴ are measured on four separate metrics—quality, resource use/cost, clinical practice improvement activities, and advancing care information.³⁰⁵ Participation is mandatory for providers who are not enrolled in an APM, with exceptions.³⁰⁶ Again, mirroring the MSSP, providers within MIPS are financially encouraged to be mindful of delivery efficiency, increasing reimbursement by providing high quality care at a lower cost.³⁰⁷ The resource use criterion directly measures a provider's efficiency. Nonetheless, challenges to the MIPS program are likely forthcoming from the Trump administration.³⁰⁸

IV. COST-CONSCIOUS MARKET ARCHITECTURE

In seeking to leave room for private market actors within the individual health insurance exchanges, the ACA adopted a model that is not unfamiliar to the history of American health law and policy: an unwavering commitment to the private market's ability to provide health insurance, but an accompaniment of substantial government-imposed regulatory guardrails. The ACA supercharged this model in that it lured private insurance companies into a previously unprofitable market (made profitable by generous subsidies) while building up the regulatory scaffolding that surrounded it. It paid private insurance companies to participate while mandating that they sell insurance to citizens with health risks they would have never previously accepted. Participation remains voluntary.

But by relying on the voluntary action of private entities—with markedly different goals than the government—to deliver health insurance to the market's customers, the scheme failed to adequately take account of conflicts of interest that naturally occur within the market. With weak market-based pressures, and devoid of regulations that sufficiently incentivize the insurance companies to limit their premium increases, the federal government—and the market's patient-beneficiaries—are simply along for the ride. This is the case, even

304. See *APMs Overview, Quality Payment Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://qpp.cms.gov/apms/overview> (last visited Jan. 24, 2020).

305. See *MIPS Scoring Methodology Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://qpp-cm-prod-content.s3.amazonaws.com/uploads/179/2018%20MIPS%20Scoring%20Guide_Final.pdf (last visited Jan. 24, 2020).

306. See *How MIPS Eligibility Is Determined*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://qpp.cms.gov/participation-lookup/about> (last visited Jan. 24, 2020) (noting that providers who participate in an alternative payment model (APM) are exempt from MIPS).

307. See *MIPS Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://qpp.cms.gov/mips/overview> (last visited Jan. 24, 2020) (“MIPS was designed to tie payments to quality and cost efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.”).

308. See Steven Porter, *Expect Big MIPS Changes Under 2019 Quality-Reporting Proposals*, HEALTH LEADERS MEDIA (July 16, 2018), <https://www.healthleadersmedia.com/welcome-ad?toURL=/clinical-care/expect-big-mips-changes-under-2019-quality-reporting-proposals>; see also Joanne Finnegan, *A Break for Doctors: Trump Administration Wants to Reduce Reporting Burden Under MIPS*, FIERCEHEALTHCARE (Feb. 22, 2018, 11:51 AM), <https://www.fiercehealthcare.com/practices/trump-budget-mips-quality-reporting-macra>.

though fraud enforcement,³⁰⁹ as well as fiduciary regulation,³¹⁰ could be brought to bear in an attempt to better neutralize these conflicts of interest.³¹¹

In other realms of health law, policy interventions based on softer incentives have been deployed for employees, restaurant visitors, soda lovers, physicians who participate in Medicare Part B, and hospitals and clinics that form ACOs. In an effort to increase enrollment on the individual market, other creative ideas—those directed toward insurance beneficiaries—have also been suggested.³¹² Although a good idea from a risk-spreading perspective in that the increased enrollment causes premiums to drop for all beneficiaries, solutions directed toward beneficiaries' enrollment decisions do not impact the price of

309. Congress made clear that the Federal Civil False Claims Act (FCA) applies to the health insurance exchanges and the individual marketplace. See 42 U.S.C. § 18033(a)(6)(A) (2018) (“Payments made by, through, or in connection with an Exchange are subject to the False Claims Act if those payments include any Federal funds.” (citation omitted)). Mirroring other areas of health law fraud and abuse enforcement, the FCA could be employed to provide additional incentives for insurance companies to limit rate increases. Mirroring cases where federal prosecutors apply the FCA to “outlier” providers who cost the federal health care programs excessive amounts of money—at least when compared to peers—the FCA could be wielded in a similar manner.

310. Legal precedent and scholarship recognize the importance of agency law—and particularly, duties belonging to agents and principals—in an effort to prevent the development of a damaging conflict of interest in certain legal relationships. In corporate law, legally-enforceable duties—most prominently illustrated by the duty of loyalty that directors owe shareholders—protect the sanctity of sensitive relationships. Within health law scholarship, scholars have argued for at least a limited recognition of a fiduciary regime in different contexts. These include an imposition (1) on the patient-provider relationship as a patient-protective tool, (2) on the hospital-discharged patient relationship to prevent harm, and (3) on the Medicare-provider relationship as a cost-savings tool, to name a few. See Isaac D. Buck, *Furthering the Fiduciary Metaphor: The Duty of Providers to the Payers of Medicare*, 104 CALIF. L. REV. 1043, 1044 (2016); Thomas L. Hafemeister & Joshua Hinckley Porter, *Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties to Their Discharged Patients*, 62 AM. U. L. REV. 513, 514 (2013); Thomas L. Hafemeister & Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U. L. REV. 1167, 1170 (2009); Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 BUFF. L. REV. 715, 726 (2011); Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1, 2 (2015); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 457 (2000) (noting the recognition of the patient-provider relationship, albeit a limited one). All of these proposals extend the relationship-based corporate law paradigm—and particularly, the duty of loyalty—to key interactions particularly dependent on trust within health law in an effort to protect more vulnerable parties and the trust upon which their efficiency-enhancing relationship is based.

311. See sources cited *supra* note 310. Those same arguments—that focus on promoting and protecting loyalty between separate parties within health law—can be extended to the ACA's individual marketplace and may provide a worthwhile frame for addressing the conflict threat on the individual marketplace. Specifically, reading in a protectable agency relationship would impose a higher duty of trust and loyalty on insurance companies tasked with providing insurance to ACA beneficiaries on the exchanges. This paradigm is applicable, not because private insurance companies and the government are *required* to cooperate to effectuate health insurance delivery to marketplace customers, but because, in effect, the federal government has enlisted the private insurance company to carry out the government's goal of providing insurance for its previously-uninsurable population. In this way, the relationship classically resembles the principal-agent relationship. In this structure, the private insurance company becomes an agent of the federal government. The application of fiduciary duties becomes natural.

312. See Susannah Luthi, *Democratic Lawmaker Eyes Partial Auto-Enrollment as Way Forward for ACA*, MOD. HEALTHCARE (Apr. 27, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180427/NEWS/180429909>.

American health care in the way that an intervention targeted at insurance companies would.

Nonetheless, the ACA's subsidies *could* be restructured to operate on the beneficiaries in a more direct manner. As mentioned above, the ACA's tax subsidies are keyed to one's household income.³¹³ This creates unnatural incentives for individuals who want to avoid pay raises, concerned about how that may impact their subsidy amount.³¹⁴ And, as also mentioned above, the subsidy structure's fragmented cliffs may prevent individuals from wanting to experience household income raises altogether.³¹⁵ Mirroring recent public health interventions, this construction—leaving subsidies to be determined solely by household income, not by socially beneficial behavior—missed an opportunity to reward “good citizens,” which would have allowed individuals who make healthy choices to receive higher government subsidy amounts. The beneficiary's agency—and their socially beneficial decisions—could be directly (and financially) rewarded.

Other supplemental regulatory changes that hold down the cost of care for individual beneficiaries—albeit ones that may be less successful in affecting the baseline cost of care—could be employed. Drawing on scholarship examining the right amount of “skin in the game” to prevent the documented problem of moral hazard,³¹⁶ perhaps additional new regulations could limit deductibles to a percentage of one's income. This would alleviate the problem of individuals feeling as though their deductibles are so expensive that they cannot afford to even access health care—the same care their expensive insurance plans seemingly guarantee.

But using the same theoretical mechanisms, there is no reason to keep similar interventions from being unleashed in the ACA marketplace beyond beneficiaries, but also to work on *insurance companies* as well. Insurance companies are the actors in the most powerful position to impact the cost of insurance, largely because of the extensive leverage they enjoy. What is striking is the absence of well-calibrated soft incentives—that are responsibly geared to impacting the behavior of insurance companies on the ACA's exchanges—that are a missed opportunity to shape behavior.

Indeed, the subsidy structure could have been wholly restructured in a way to incentivize and nudge *insurance companies* themselves—the actors that are seeking year-over-year premium hikes—to neutralize some of the worst conflicts of interest on the market. Relying on behavioral economics literature, the subsidies could have been calibrated to seek to influence the behavior of insurance companies that would have made the decision to raise premiums *costlier for the insurance companies themselves*. This would have the upside of

313. See *supra* notes 189–197 and accompanying text.

314. See *supra* notes 189–197 and accompanying text.

315. See *supra* notes 189–197 and accompanying text.

316. See Pauline Bartolone, *When High Deductibles Cause Even Insured Patients to Postpone Care*, CNN (Aug. 5, 2017, 10:13 AM), <https://money.cnn.com/2017/08/05/news/economy/high-deductibles-insured-health-care/index.html>; Robertson, *supra* note 237, at 239.

not only making health insurance more affordable but would also sharpen an incentive that—in the current ACA market—is too dull: this would pressure insurance companies to seek additional discounts from health care providers, including both hospitals and physicians.

Instead of just paying based on a beneficiary's household income, the federal government could have structured the subsidies in a way that encouraged and incentivized insurance companies to set prices lower. For example, the federal government could have imposed a "tiered" subsidy plan with its subsidy payments, so as to reward efficient insurance companies by paying *larger* subsidies to those who hold down premium increases year over year. This could be accomplished through either paying direct subsidies to the most efficient insurance companies, or by using the beneficiaries as indirect conduits. This structure would seek to steer beneficiaries—through rewards with tax subsidies—toward more efficient and cost-conscious insurance companies.

To accomplish this, beneficiaries who select a particular plan—one that was quite efficiently priced—could be rewarded with *higher* subsidies. If a consumer is paid more money for choosing a more cost-conscious plan, more consumers would be pushed to purchase the plans sold by the cost-conscious insurance company. As a result, persistently expensive insurance plans may face the cold reality of shrinking market share.

Assuming the subsidy gain was sufficient, this arrangement would push insurance companies that sell plans on the individual marketplace to spend more of their focus on holding down annual premium amounts, providing a powerful counterweight to the pressure they feel to continue to raise premiums. The key function of this new arrangement would be to encourage insurance companies to think harder when setting premium amounts for the marketplace's following year. This would also push insurance companies to drive aggressive negotiations with providers and hospitals, providing another, more potent tool to push the "sellers" of American health care to lower their prices *on the front end*.

As an alternative to the subsidy structure, the payments could instead be structured as a tax—similar to the soda taxes deployed in Philadelphia—that would penalize insurance companies that seek the highest percentage of premium increases. Or they could be structured like an incentive payment that mirrors the MSSP—insurance companies that achieve cost savings, or at least limit health care premiums the most, could be rewarded with higher subsidy payments from the federal government (or indirectly, through subsidies originally given to beneficiaries). However structured, this new mechanism would evince a clear policy choice for those insurance plans that operate in a leaner way.

A secondary goal would surely follow. Pressed to limit premium increases so as to increase subsidy amounts, insurance companies would approach network negotiations with hospitals and physicians in a more powerful position. Currently blunted from fighting health care price increases too strongly by the MLR and other market failures, the new subsidy architecture would make the

insurance company that saves its beneficiaries more money, *more* profitable. Like physicians participating in Medicare's Shared Savings Program, the federal government would be sharing savings with insurance companies on the exchange, literally paying carriers to operate with cost efficiency at front of mind.

Whatever policy solution is ultimately furthered, market subsidies could be creatively restructured in a way that more clearly address the worst inefficiencies of the individual marketplaces that have struggled to survive. Employing important lessons from behavioral economics—meant to encourage these actors on the ACA exchanges into making more pro-social business decisions—could provide a guiding platform for powerful changes to the marketplaces. The counterweight could effectively insulate more Americans from the worst costs of American health care.

Although the thrust of this proposal—to build-in and instantiate societally-beneficial price pressures in the insurance markets—contemplates the injection of corrective incentives, there are limits of the proposal that are worth mentioning. The biggest challenge to the proposal is that it would have to be implemented by states or the federal government in the insurance marketplaces they run.³¹⁷ The likelihood of the states and federal government—given the political volatility of the ACA markets and the inner-workings of the law—seems relatively low at this point. State actors have been hesitant to touch the ACA, largely for reasons related to politics. Nonetheless, more states seem interested in stepping up to address some of the worst of the market's inefficiencies, often providing a corrective to federal government policies that have damaged the health of the private ACA marketplaces.³¹⁸

But, assuming implementation, the other major challenge revolves around adequately calibrating the shared savings subsidies. Should the subsidies be too meager, they would be unlikely to sufficiently impact insurance companies' behavior. Should the subsidies be too great, insurance companies may cut *too many* health care services from their required coverages. To the extent that ACA regulations on essential health benefits are enforced, this would help to prevent this problem.³¹⁹ Still, cost-cutting could result in more narrow networks for beneficiaries, frustrating their efforts to see a specialist or specific provider. A key consideration here would be to ensure the subsidies are neither too cold nor

317. Currently, twenty-six marketplaces are completely run by the federal government. See Louise Norris, *What Type of Health Insurance Exchange Does My State Have?*, HEALTHINSURANCE.ORG (Oct. 9, 2019), <https://www.healthinsurance.org/faqs/what-type-of-health-insurance-exchange-does-my-state-have/>.

318. See Meredith Cohn, *Lawmakers Seek to Create State Mandate to Push More Marylanders into Health Insurance*, BALTIMORE SUN (Nov. 20, 2018), <https://www.baltimoresun.com/health/bs-hs-aca-individual-mandate-20181113-story.html>; Katie Keith, *New Jersey Becomes Second State to Adopt Individual Mandate; Ohio Attempt to Waive Mandate Rejected*, HEALTH AFF. BLOG (June 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180601.345116/full/>.

319. *Quick Take: Essential Health Benefits: What Have States Decided for Their Benchmark?*, KAISER FAM. FOUND. (Dec. 7, 2012), <https://www.kff.org/health-reform/fact-sheet/quick-take-essential-health-benefits-what-have-states-decided-for-their-benchmark/>.

too hot—a lesson learned through trial and error during an important implementation period.

A final challenge to successful implementation would be participation. It is not hard to imagine a scenario in which no insurance company elects to restrict its costs to achieve subsidies. For instance, if no insurance company decides to be impacted by the subsidy arrangement—recognizing such an arrangement is strictly voluntary—there is nothing that would require them to enroll in such a program. Nonetheless, the profit pressure—as well as pressure from its shareholders to generate increasing profits—may push companies into participating in a shared savings program.

CONCLUSION

That the ACA is both still substantially intact and remains under existential threat illustrates both its striking resiliency and the proximity of peril. Its strengths and weaknesses track a dichotomous history within American health care. Indeed, for generations, Americans have been skeptical of government involvement, but uncomfortable with relying on the cold reality of the market. Besides distorting and constricting the development of American health care law and policy, these conflicting beliefs have resulted in both a bloated and under-regulated non-system, one that continues—even after the ACA—to prove its unworkability for millions of Americans. Citizens now have access to insurance, but the cost of care remains an insufficiently addressed challenge.

Seen by some as a turn away from the chaotic decades that preceded it, the ACA did not sufficiently account for America's cost crisis. Its individual marketplace—hampered by a lack of competition—continues to struggle. But new ideas from behavioral economics, deployed in other areas within health law itself, could be brought to bear in an effort to bring down the cost of insurance, providing a powerful counterweight to the conflicts of interest that continue to incentivize insurance companies to operate at cross-purposes with a desire to bring down the costs within the system. These changes could put the ACA on more secure political footing and, most importantly, may prove an effective tool in working toward finally reining in the cost of American health care.

Preprint not peer reviewed