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The Affordable Care Act and the Chronic Challenge of Cost Control

Isaac D. Buck

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THE AFFORDABLE CARE ACT AND THE CHRONIC CHALLENGE OF COST CONTROL

By: Isaac D. Buck[†]

Thank you, Derek, and thank you all for having me. First of all, I would like to congratulate the Journal on a wonderful symposium topic this year, a theme that is uniquely newsworthy. Nonetheless, considering this is the focus of much of my waking hours, scholarship, and teaching, I may be biased. But I thank you for bringing together stellar voices to have this conversation and for providing a platform for such a vital topic.

In my talk, I'd like to move beyond focusing solely on the Affordable Care Act ("ACA"), or even specific health insurance reforms, and widen the analysis. Instead of speaking on the constitutional law implications of litigation surrounding the ACA, I'll be focusing on one of the most daunting health policy challenges facing the American health care system in 2017. Nonetheless recognizing that the symposium is organized around the impact of *NFIB v. Sebelius*,¹ I'll be sure to wrap the case into later comments. But in my estimation, the debates of the day, that focus both on the recently abandoned American Health Care Act ("AHCA") and the battered and embattled ACA, avoid a necessary holistic discussion of the American health care system. In some ways, the reform debate has been co-opted: instead of talking about existential challenges within American health care, the extended health reform debate has focused instead on the ACA's so-called "government takeover."

This debate has replayed for seven years; it has been focused on the effectiveness of websites, on the increasing amounts of premiums in the individual marketplace without a corresponding discussion of the extensive subsidies that support them, and the debate regarding, of course, whether Obamacare and the ACA are in fact the same thing. Following the collapse of the AHCA effort, national media

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¹ *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

characterized it as a political failure of the Trump administration while noting that Obamacare—without specifying what specific part—was still tenuous.

But these debates and narratives obscure the entirety of what the ACA does. Sure, individual markets have struggled, including my home market of Knoxville, Tennessee, but characterizing the entire law as “failing” is not only misleading, it’s untrue. This is the law that established the rights of 26-year-olds to stay on their parents’ plans, that outlawed preexisting condition discrimination, that provided funding for evidence-based medicine and fraud and abuse enforcement, that sought to increase reimbursement efficiencies in Medicare, and provided free preventive and contraceptive care to millions of previously-uninsured Americans.

I grant that the ACA is complicated and nuanced and some pieces have not been as successful as anticipated, but by focusing on the political fights over websites, we have allowed some of the ACA’s strongest attributes regarding cost control to flounder. As a result, we have left millions of Americans unaware of the good that the ACA is doing, and has done, in their lives largely until recently. And in this environment, it is impossible to have productive policy debates focused on America’s big problems. Nonetheless, it is true that the failure of the ACA to “break through” and provide clear tangible positives in citizens’ lives, of which they are keenly aware, could constitute a real critique of the messaging of the law. Health care delivery and finance has no shortage of complexity.

Which brings us to the AHCA, a plan which, in the end, had few supporters. Indeed, the AHCA focused its energy on shrinking and fundamentally altering two things: the individual marketplace and Medicaid. The debates focused on whether 23 million Americans—who have been insured under the ACA—should be kicked off their health insurance plans by 2026,² whether Medicaid should be fundamentally remade to incorporate work requirements and cease being an entitlement program for many of the nation’s poor, and whether health care reform as a policy matter could work without an individual mandate. As you may have guessed, I thought these reforms under the AHCA were misguided and doomed to fail, and indeed, they did in the end, last week.

² See Danielle Kurtzleben, *GOP Health Plan Would Leave 23 Million More Uninsured, Budget Office Says*, NPR (May 24, 2017), <http://www.npr.org/2017/05/24/529902300/cbo-republicans-ahca-would-leave-23-million-more-uninsured>

From a policy perspective, an individual market without a mandate would produce sicker, more expensive insurance pools. Medicaid without secure funding would result in deep cuts in coverage and access, essentially changing a program that has become a lifeline for many (including children and the elderly), and capping the tax subsidies given to those who cannot afford insurance would result in fewer people signing up for coverage, more expensive premiums, and a growing number of uninsured individuals showing up in the nation's emergency rooms.

As the *New York Times* stated, the AHCA was a “bill in search of a problem” and that it reflected “no shared vision” of what it wanted to achieve.³ Its reforms were likely to worsen health coverage, access, and outcomes. Perhaps it was the newest attempt at delivering a death blow to Medicaid, which covers more than 70 million Americans and pays for nearly half the births in this country every year.⁴ But it, like so many other health reform efforts before it, never made it into law, nor even to the upper chamber of Capitol Hill. Given the omnipresence of these debates, we can talk about arguments over the reforms and the potential threats they create, but for the remainder of my talk, I want to speak more specifically about America's existential challenge: the challenge of the cost of health care in the United States in 2017.

First, by larger, I don't mean more consequential, particularly for the millions of Americans who were at risk of losing insurance under the AHCA or other repeal efforts. Instead, I mean a cost challenge that is so daunting that it will likely inhibit the success of *any* health care reform effort in the United States in the near future. Indeed, it has hamstrung the ACA as well; this is because the pricing and utilization challenges in the U.S. swamp the ability of health reform efforts, like the ACA and AHCA, to achieve real cost control. If one could imagine the cost challenge as a chronic condition, after sustaining a number of body blows, the ACA treats the symptoms of the condition while only limitedly impacting the overall cost of health care. Nonetheless, the AHCA would have exacerbated them, but in order for an American health care reform effort to find political purchase, I submit that the underlying cost challenge must be directly

³ Editorial, *A Republican Health Care Bill in Search of a Problem*, N. Y. TIMES (Mar. 21, 2017), <https://www.nytimes.com/2017/03/21/opinion/a-republican-health-care-bill-in-search-of-a-problem.html?mcubz=1>.

⁴ See Phil Galewitz, *Nearly Half of U.S. Births Are Covered by Medicaid, Study Finds*, KAISER HEALTH NEWS (Sept. 3, 2013), <https://khn.org/news/nearly-half-of-u-s-births-are-covered-by-medicaid-study-finds/>.

and forcefully addressed. Besides being complex, what makes the cost challenge so daunting is that there is seemingly little political will to directly address it.

Over just the last two years, stories of the prices of Mylan's EpiPen⁵ and Martin Shkreli's Daraprim⁶ hit the national news and sparked outrage. Americans, even those with insurance, still too often face surprising health care bills after coming home from a hospital stay. Employers face increasingly difficult decisions about coverage for their employees. Insurance companies are losing leverage in the marketplace. But none of these stories and pressures have resulted in congressional action in Washington on the price of health care.

Instead, the rising prices of health care have been blamed on the ACA. As a result, the larger debate then centers on the specific policy prescriptions of the ACA or its replacement and not on the fundamental problem: that American health care is simply too expensive. No amount of tax subsidy or increased access is going to address that problem. If Americans really are serious about health care reform, they need to stop ignoring the elephant in the room, to paraphrase David Wolman in the context of drug pricing, that "prices are too damn high."⁷ And where the ACA sought to make inroads in cost control, political hostility has wounded it.

So now, on to the numbers. Americans spend about 18 percent of our gross domestic product ("GDP") on health care, totaling well over three trillion dollars each year.⁸ We spend the most per capita on health care of any country in the world by a large margin, far outpacing our peers in the United Kingdom and Australia, which both spend just under 10 percent of their GDPs, respectively.⁹ Expressed in per capita

⁵ See *Rising Cost of Potentially Life-Saving EpiPen Puts Pinch on Families*, CBS NEWS (August 16, 2016, 7:02 AM), <https://www.cbsnews.com/news/allergy-medication-epipen-epinephrine-rising-costs-impact-on-families/>.

⁶ See Andrew Pollack, *Drug Goes From \$13.50 a Tablet to \$750, Overnight*, N. Y. TIMES (Sept. 20, 2015), <https://www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html?mcubz=1>.

⁷ David Wolman, *Drugs Prices Are Too Damn High. Here's How to Fix Them*, WIRED (Dec. 12, 2015, 6:40 AM), <https://www.wired.com/2015/12/rising-drug-costs/>.

⁸ See *National Health Expenditure Fact Sheet*, CTRS. FOR MEDICARE AND MEDICAID SERVS., (June 14, 2017), <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>.

⁹ See Chloe Anderson and David Squires, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries*, THE COMMONW. FUND (Oct. 8, 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>.

terms, we spend about \$9,000 per year per capita on health care¹⁰ whereas Switzerland spends about \$6,800,¹¹ Germany about \$5,100,¹² and Australia less than half, at \$4,200.¹³

This is not a new challenge, but America's expenditure crisis has intensified in recent years. As recently as 1980, America spent just 8 percent of its GDP on health care.¹⁴ This number rose in the 1990s and 2000s.¹⁵ It is a crisis that has sharply intensified over the last 35 years. Health care expenditures are now increasingly eating into other goods and services Americans can purchase and fund, like education, defense, and travel. Of course, one could ask, "what else would you want to spend 18 percent of your GDP on?" But it would indeed be a different question if our elevated budget bought better health care for our citizens.

Unfortunately, this lofty budget does not translate into increased quality. Compared to its peers, America still lags behind on a number of key quality metrics. According to recent data from the Organisation for Economic Co-operation and Development ("OECD"), the United States is above average on infant mortality.¹⁶ And America is 27th out of 43 OECD countries on life expectancy.¹⁷ Further, another survey, completed by the Commonwealth Fund, ranks the health systems of eleven countries.¹⁸ A survey published in 2014 by the Fund noted that the U.S. health system "underperforms relative to other countries on most dimensions of performance," and the survey had America ranked last on its quality metrics,¹⁹ just as it did in 2010, 2007, 2006, and 2004.²⁰ Recent studies have also concluded that America has few practicing physicians and doctor consultations per

¹⁰ See *Per Capita Healthcare Costs – International Comparison*, Peter G. Peterson Foundation (Oct. 17, 2016), http://www.pgpf.org/chart-archive/0006_health-care-oecd.

¹¹ See *id.*

¹² See *id.*

¹³ See *id.*

¹⁴ See *Snapshots: Health Care Spending in the United States & Selected OECD Countries*, THE HENRY J. KAISER FAM. FOUND. (Apr. 12, 2011), <http://www.kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/>.

¹⁵ See *id.*

¹⁶ See *OECD Family Database: CO1.1: Infant mortality*, ORG. FOR ECON. CO-OPERATION AND DEV., (Aug. 27, 2006), https://www.oecd.org/els/family/CO_1_1_Infant_mortality.pdf.

¹⁷ See *Life Expectancy at Birth*, ORG. FOR ECON. CO-OPERATION AND DEV. (2015), <https://data.oecd.org/healthstat/life-expectancy-at-birth.htm#indicator-chart>.

¹⁸ See Karen Davis, et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, THE COMMW. FUND (June 16, 2014), <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>.

¹⁹ See *id.*

²⁰ See *id.*

capita compared to the OECD average,²¹ and, of course, without adequate numbers of physicians, particularly in primary care, the underlying problem intensifies.

There are two contributors to the expenditure challenge facing American health care: utilization and pricing. The utilization problem is due to America's providers administering too much health care, and the pricing challenge is due to the excessive costs of America's health care services, drugs, and equipment. In short, in the United States, American providers perform too many surgeries, administer too many tests, and intervene too frequently—and much of what providers do is too expensive.

On the first point, American health care is dogged by overutilization, of which I have written before, or overtreatment, to which it is frequently referred. In trying to explain why the American health care system administers too many health care services, one could examine numerous causes: perhaps it is reimbursement incentives, malpractice litigation or defensive medicine, demanding patients, fragmented health care delivery systems and medical siloization, or expensive technological advancement. Personally, I think all probably play a role.

Historically, America has been unable, first, to adequately pressure physicians to care about cost efficiency and, even more than that, has inexplicably built a reimbursement structure through Medicare, at least historically, that has incentivized overtreatment. Over 50 plus years, when providers have performed additional tests and arguably unnecessary surgeries, they have earned more in Medicare's fee-for-service reimbursement regime. Further, providers have been pressured to perform additional screens on patients who may have complicated presentation due to a fear of malpractice litigation and because the patient may be demanding it, and, honestly, because practicing medicine is intensely difficult, and when providers are faced with a patient who presents complicated problems, they may want to double-check. Uncertainty causes anxiety, and anxiety seeks a definitive answer to a complicated medical problem.

Paraphrasing author Shannon Brownlee, a provider seeking a definitive answer is likely to rely on additional screening machinery, especially if the patient wants it, and especially when the provider's time is tight.²¹ Additionally, American health care is persistently

²¹ See Anderson & Squires, *supra* note 8.

²¹ See Shannon Brownlee, *Why Your Doctor Has No Time To See You*, NEWSWEEK (April 16, 2012), <http://www.newsweek.com/why-your-doctor-has-no-time-see-you-63949>.

fragmented and siloed. Providers are financially incentivized to specialize further and further because the specialties that require additional training and work often are the most financially lucrative. American patients often see a number of providers without having adequate primary care—the country faces a shortfall numbering somewhere between 46,000 and 90,000 physicians by 2025.²² As a result, care is often duplicated and wasted, and inefficiencies permeate the system.

Finally, somewhat counterintuitively, technological advancement leads to overtreatment as well. Hospitals that have recently acquired expensive top-of-the-line machinery feel compelled to use it to pay for it. The more they acquire, the more they have to use. And this is borne out by the numbers in the surveys that I mentioned before. America does well at screening for cervical cancer, for instance, but terrible in treating childhood asthma, reflecting great screening capabilities, which is highly expensive, but poor primary and preventive care, which is largely inexpensive.

In addition to the overtreatment challenge which largely drives excess costs in government insurance program of Medicare, American health care is hamstrung by astronomical costs because the prices of health care in the United States—that is, the initial prices of drugs, services, and hospital stays—are more expensive in this country than anywhere else in the world. Reporting by the *New York Times* particularly recent work by Elizabeth Rosenthal, has shined a light on this problem.²³

According to Rosenthal, the average colonoscopy in the U.S. costs \$1,200; it is priced at \$600 in Switzerland.²⁴ The average hip replacement in the U.S. is over \$40,000, and in Spain, it is \$8,000.²⁵ The cost of a prescription of Lipitor is \$120.²⁶ In New Zealand, it is

²² See *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025*, ASS'N OF AMER. MEDICAL COLLEGES, at 42 (Mar. 2015), <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

²³ See Elisabeth Rosenthal, *Paying Till It Hurts*, N.Y. TIMES (2014), <https://www.nytimes.com/interactive/2014/health/paying-till-it-hurts.html> (interactive site with multiple articles).

²⁴ See Elisabeth Rosenthal, *The \$2.7 Million Medical Bill*, N.Y. TIMES (June 1, 2013), <http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?pagewanted=all>.

²⁵ See *id.*

²⁶ See *id.* See also Matthew Herper, *How to Charge 1.6 Million For A New Drug and Get Away With It* (March 19, 2012), <https://www.forbes.com/sites/matthewherper/2012/03/19/how-to-charge-1-6-million-for-a-new-drug-and-get-away-with-it>.

\$6.²⁷ An American angiogram costs \$900; in Canada, it costs \$35.²⁸ An MRI in America is \$1,100 on average and in the Netherlands, it is about \$300.²⁹ In addition to the international differences, prices between and among hospitals, even some in the same region or community, vary wildly, seemingly without any regard for quality or for service.

Even more inexplicably, the opaque pricing structure within American health care actually often leads hospitals to charge those without insurance more, at least initially, as they do not have the benefit of the insurance company's discounts. There are a number of examples of perverse pricing within Medicare's reimbursement structure. For instance, in a recent paper, I discussed pricing differences between the two drugs of Avastin and Lucentis,³⁰ both drugs that treat age-related Macular Degeneration ("AMD"). Millions of Americans are affected by AMD each year and, as a result, of course, many of them are elderly Americans; as a result, Medicare covers both drugs without limitation.

Interestingly, both drugs of Lucentis and Avastin are manufactured by the same company, Genentech, and after numerous studies, both have been found to be basically clinically equivalent in their effectiveness against AMD.³¹ Seemingly, the only clinical difference is that one of the drugs is Food and Drug Administration ("FDA") approved for AMD treatment, and the other one is used in an off-label manner, but is commonly used to treat AMD.³²

The only other difference, of course, is the prices of the drugs. Avastin is \$50 per dose,³³ and Lucentis is \$2,000 per dose.³⁴ After

²⁷ See Rosenthal, *supra* note 24.

²⁸ See *id.*

²⁹ See *id.*

³⁰ See Isaac D. Buck, *The Cost of High Prices Embedding an Ethic of Expense into the Standard of Care*, 58 B.C. L. REV. 101 (2017).

³¹ See Marilyn Haddrill, *Lucentis Vs. Avastin: A Macular Degeneration Treatment Controversy*, (Dec. 2016), <http://www.allaboutvision.com/conditions/lucentis-vs-avastin.htm>.

³² See *id.*

³³ See Peter Whoriskey & Dan Keating, *An effective eye drug is available for \$50. But many doctors choose a \$2,000 alternative*, THE WASH. POST (Dec. 7, 2013), https://www.washingtonpost.com/business/economy/an-effective-eye-drug-is-available-for-50-but-many-doctors-choose-a-2000-alternative/2013/12/07/1a96628e-55e7-11e3-8304-caf30787c0a9_story.html.

³⁴ See *id.*; Andrew Lam, *Why do Doctors Choose a \$2,000 Cure When a \$50 One is Just as Good?*, THE WASH. POST (Dec. 10 2015), <https://www.washingtonpost.com/news/wonk/wp/2015/12/10/why-do-doctors-choose-a-2000-cure-when-a-50-one-is-just-as-good>.

discounts, Medicare pays about \$26 for Avastin,³⁵ and about \$1,900 for Lucentis.³⁶ This is an unfortunate enough development, of course, but Medicare makes it worse. Under Medicare's Part B reimbursement scheme—because the drugs are administered in doctor's offices—Medicare pays ophthalmologists the average sales price (ASP) of the drug plus 6 percent.³⁷ It is known as “ASP plus six.” As a result, doctors who rely on Avastin can make about \$3 on the administration of the drug, whereas doctors who rely on Lucentis can make about \$120, which is 6 percent of \$2,000.³⁸

A CMS effort to change this reimbursement mechanism in the waning days of the Obama administration was recently abandoned.²² Instead, this enduring reimbursement scheme not only financially incentivizes doctors to rely on the most expensive drug for treatment of their patients, which is why it is no small miracle that 56 percent of all ophthalmologists choose the cheaper Avastin to treat AMD,³⁹ but it indirectly incentivizes drug companies to price their drugs even higher than they otherwise would.

Finally, in health care, the power of the consumer is nearly nonexistent. Patients do not reliably act like consumers and operate at a pervasive information gulf. As Carl Schneider and Mark Hall have noted, patients are boundedly rational in every aspect of a clinical scenario.²³ On top of this, they are often in pain or frightened. On top of these challenges, typical consumer-protection mechanisms are simply inapplicable in the health care context: in no other industry could a consumer expect to not know the price of the goods she purchases before paying for the services.

Thus, American health care system then is both uniquely expensive and generally mediocre, and although the debates over access and insurance status dominate headlines today, insufficient day-to-day attention has been paid to universal cost and quality problems.

³⁵ Emily Parker, *OIG: Avastin A Better Buy For Wet AMD*, MEDPAGE TODAY (April 25, 2012), <https://www.medpagetoday.com/practicemanagement/reimbursement/32359>.

³⁶ Whoriskey and Keating, *supra* note 33.

³⁷ See Andrew Pollack, *Genentech Offers Secret Rebates for Eye Drug*, N.Y. TIMES (Nov. 3, 2010), <http://www.nytimes.com/2010/11/04/business/04eye.html>.

³⁸ *See id.*

²² Virgil Dickson, *Mandatory Participation Killed the Part B Demo*, MOD. HEALTHCARE (Dec. 16, 2016), <http://www.modernhealthcare.com/article/20161216/NEWS/161219925>.

³⁹ Whoriskey and Keating, *supra* note 33.

²³ See Carl E. Schneider and Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?*, 35 AM. J.L. & MED. 7 (2009); Mark A. Hall and Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008).

But that is not to say that reforms in this area have not been attempted and have succeeded. One need look no further than March 23, 2010.⁴⁰ By striving for universal coverage, the ACA tried to begin to address these challenges: examples I will focus on here are cost-shifting and negotiating leverage.

First, the ACA attempted to address cost-shifting, which is a driver of excessive pricing. Cost-shifting stands for the reality that hospitals will charge those with insurance more to cover the costs for those who come to the emergency room without insurance and who cannot pay. Under the ACA, if all individuals are covered by insurance (even if the insurance is Medicaid that typically has relatively low comparative reimbursement rates for hospitals and providers), then hospitals would not have as powerful an incentive to cost-shift than they do when a substantial percentage of the population is uninsured. If the ACA succeeded in extending coverage universally then, theoretically, the cost-shifting impetus would have been removed or sated, and prices of health care—the prices of hospital services, for instance—could have theoretically dropped or at least stabilized.

Second, the ACA sought to address the negotiating leverage problem. One of the challenges of American health care is its fragmented delivery system. By forcing millions of Americans into an individual marketplace through the individual mandate, the ACA was broadening its risk pools and deepening its coverage, which gives insurance companies more leverage in negotiating with hospitals because the company represents a larger network of beneficiaries. For example, if insurance companies represent a substantial chunk of the market in a given state, then the insurance company may have more leverage in its negotiations over prices with hospitals. Hospitals must be willing to deal, and, theoretically, the discounts steepen.

The negotiation over prices that insurance companies pay often boils down to who has more leverage, the hospital or the insurance company. When more potential patients are represented by the insurance company, then it often has more leverage. Adversely, when the hospital consolidates market power, prices rise. This is borne out by numerous studies—including a study published late last year by the Health Care Pricing Project, which found that hospital prices in monopoly markets were 15 percent higher than those in markets with

⁴⁰ Sheryl Gay Stolberg and Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES (Mar. 23, 2010), <http://www.nytimes.com/2010/03/24/health/policy/24health.html>.

four or more hospitals.⁴¹ Given what we know about monopolies and pricing, that finding should not be surprising.

Further, when hospitals merge, prices increase. And America's health care industry is rapidly consolidating. According to Deloitte in 2014, "if horizontal consolidation continues in the coming decade, ... likely only 50 percent of [2014's] unique health systems are expected to remain."⁴² Of course the consolidation of the marketplace has made the pricing problem worse.

And this is where *NFIB v. Sebelius*—the U.S. Supreme Court's ruling that the individual mandate was a tax and thus permissible, but that the Medicaid expansion was unduly coercive, and had to be voluntary—becomes important.⁴³ In the decision, Chief Justice Roberts both saved the ACA, but wounded its operation—particularly as it relates to cost control—by allowing states to opt out of Medicaid expansion. In this opinion, the court not only limited its operation of the ACA, but it destroyed one of the ACA's intended tools to control the cost of health care: its effort to address cost-shifting. Following the Supreme Court's decision, and with more people uninsured in states that did not expand their Medicaid program, the cost-shifting problem continued, unabated. This was exacerbated by the proposal to cut other funding to hospitals, including, like Professor Huberfeld mentioned, disproportionate share payments, although some of the cuts have been delayed.

Nonetheless, in many rural parts of the country, the *NFIB* decision has hastened the downfall of hospitals facing tremendous budgetary shortfalls, putting in place a future of decreasing federal subsidies and limited insurance coverage in states that do not expand Medicaid. Particularly in my former home state of Georgia, eight rural hospitals have closed since 2010.⁴⁴ As a result, the solution to the cost-shifting problem was blunted in these states. From a global cost perspective, this is the ultimate result of the Medicaid decision in *NFIB*. And politically, the Affordable Care Act has suffered because of rising premiums and an unsteady individual marketplace.

⁴¹ Zach Cooper, et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, HEALTH CARE PRICING PROJECT (Dec. 2015), at 3.

⁴² Ion Skillrud, et al., *The Great Consolidation: The Potential for Rapid Consolidation of Health Systems*, Deloitte Center for Health Solutions (2014), at 9, <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-great-consolidation-111214.pdf>.

⁴³ *Sebelius*, 567 U.S. at 566.

⁴⁴ Ariel Hart, *Eighth Rural Hospital to Close Since 2010*, ATLANTA JOURNAL-CONSTITUTION (Apr. 27, 2017), <http://www.myajc.com/news/eighth-rural-hospital-close-since-2010/YBjgX2BKelhwNMSsMarIwJ/>.

But again, had parts of the law been implemented as intended, perhaps these marketplaces would have been more functional. As an example, an important part of the ACA was known as the risk corridor adjustment program whereby the Department Health and Human Services (“HHS”) from 2014 through 2016 would spread the risk among insurers who participated in the marketplaces at the end of each year.⁴⁵ This was seen as a safety net for insurance companies, in the event they took on patients that ended up being riskier than the pool average and more expensive than anticipated.

Nonetheless, Congress blocked HHS from making these risk corridor adjustment payments and ultimately permanently stripped them from HHS discretion. As a result, for instance, HHS paid slightly more than 12 percent of promised risk corridor payments in 2014.⁴⁶ And health insurance companies have sued for the payments. Moda Health scored a big win in February of 2017 in the court of federal claims, alleging that it was due payments under the risk corridor program.⁴⁷ These moves by a hostile Congress, in addition to the continued unprecedented consolidation of health care markets—perhaps even hastened by the ACA—have intensified the cost problem and impacted patients.

But the ACA has sought to address the rising cost of health care on other fronts. The law pushed hospitals to form Accountable Care Organizations,⁴⁸ which are new entities where providers and entities share financial risk and are incentivized to achieve cost savings within their systems. It also has sought to arm patients with more consumer information. Further, by covering preventative care, the ACA seeks to avoid the down-the-line expensive consequences that currently face too many uninsured Americans. To quote law professor James Kwak, this is “significantly better than nothing.”⁴⁹ As Kwak argues in his blog piece, *The Problem with Obamacare*, the ACA relies on a model that utilizes private markets to expand coverage and on broad market-based solutions like increased cost-sharing through raised deductibles to

⁴⁵ Cynthia Cox, et al., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridor*, HENRY J. KAISER FAMILY FOUNDATION (Aug. 17, 2016), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.

⁴⁶ *Id.*

⁴⁷ Maria Castellucci, *Feds Must Pay Moda Health \$214 Million over Risk-Corridor Program*, *Modern Healthcare* (Feb. 9, 2017), <http://www.modernhealthcare.com/article/20170209/NEWS/170209896>.

⁴⁸ Jenny Gold, *Accountable Care Organization, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <https://khn.org/news/aco-accountable-care-organization-faq/>.

⁴⁹ James Kwak, *The Problem with Obamacare*, THE BASELINE SCENARIO (May 9, 2016), <https://baselinescenario.com/2016/05/09/the-problem-with-obamacare/>.

deter overuse and risk adjustment provisions to keep insurance companies participating.⁵⁰ But as he ultimately says, “Obamacare is a heroic attempt to make the best out of this basic conundrum: 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.”⁵¹

And due to political hostility, the *NFIB* case, the widespread confusion over what the law does, and the complexity over the subject itself, the ACA’s attempt to incorporate market-based solutions—along with its reliance on the private insurance industry to participate in the markets—leaves it unable to adequately address America’s cost control problem, and as a larger result, politically vulnerable. It is a step in the right direction, but only a step.

Fragmentation, overtreatment, and excessive pricing continue in the American enterprise. As a result, monthly premiums will rise, not just for those newly insured in the exchanges but those Medicare beneficiaries who pay premiums, and those covered by their employers as well. Serious health care reform efforts must address these bedrock cost concerns. Without adequate attention to, and focus on, the cost of health care, efforts that merely try to insulate further Americans from feeling the pain of the cost of health care will be increasingly ineffective.

Until American voters and legislators come up with bold new ideas to fix fragmentation that continues to dog the markets, to engage in robust antitrust efforts, to better address consolidation, and to institute price ceilings, or all-payer rate setting laws, or public options, or single payer plans, to hold down the price of the rising prices of insurance, until this happens, prices in American health care will continue to rise. And without concerted intervention, even with other reforms—whether under President Trump or his successor or successors—these cost pressures will continue to threaten the nation’s leaders’ political success, how the reforms are perceived by the public, and the quality and sustainability of American health care well into the future.

⁵⁰ *Id.*

⁵¹ *Id.*