

THE PRICE OF UNIVERSALITY
SUSTAINABLE ACCESS AND THE TWILIGHT OF THE ACA

Isaac D. Buck

The Patient Protection and Affordable Care Act of 2010 (ACA) was intended to solve problems that had dogged American health care for generations. It built a comprehensive structure—by providing more Americans with accessible health insurance, revamping and 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 in millions of Americans’ lives.

However, over the last eight years, the ACA has faced persistent political, popular, and policy-based challenges. It remains tenuous as its prominent insurance marketplaces precariously teeter. The law’s imperfections continue to fuel an uninterrupted barrage of legal, administrative, and regulatory attacks, which, piece by piece, weaken its overall effectiveness. Its failure to impact the cost of health care has continued to haunt it, making it unclear whether it will fully collapse or whether a mutated version of itself will lumber into the future. Either may be devastating to the future of American health care.

In sum, the ACA did not change the dominant paradigm of America’s health care system because it failed to bring about meaningful cost control. While it may have relieved some of America’s worst tendencies, it further cemented a health care non-system, one whose technocratic tinkering could not tape over cracking foundation. Instead of installing a comprehensive system, the ACA opted to try to protect American patients and beneficiaries from the market’s worst effects without any effective means for cost control. In this way, the ACA clearly fit into the dominant dichotomous health care paradigm: America views health care both as a right and as a consumer good, both a foundational human need and a risk pool, and prefers both the cold market and state subsidies. As a result, the ACA became the posterchild of the problem it presumably sought to solve, melting into a confusing hybrid of market-based solutions and state intrusions, leaving conflicted health law and policy scaffolding in its wake.

And now, with the evaporation of the individual mandate, this piece places the ACA’s cost control failures, its incomplete solution of “structural access,” and its reliance on corporatization in context. It further explores what a more successful but realistic policy paradigm could resemble, in an effort to imagine what could follow a disintegrating ACA. The ACA experience is replete with lessons for future efforts.

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INTRODUCTION

For much of the last century of American health law and policy, a delicate balance has been struck between universality and exclusivity, laws and markets, resulting in fragmented implementation and culminating in political volatility.¹ Health care in America is *both* an open, public emergency room *and* the raw ruthlessness of the private insurance marketplace. America wants *both* universal coverage² *and* work requirements for certain³ Medicaid beneficiaries—a policy sure to shrink the insurance rate.⁴ It demands cheaper pharmaceutical drugs but bemoans being overregulated.⁵ It provides generous and

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¹ Support for the Affordable Care Act has swung over the last eight years—from a low of 33 percent support in Nov. 2013, to a high of 52 percent in August of 2017. See Ashley Kirzinger, et al., *Kaiser Health Tracking Poll—August 2017: The Politics of ACA Repeal and Replace Efforts*, KAISER FAMILY FOUNDATION, Aug. 11, 2017, available at <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-august-2017-the-politics-of-aca-repeal-and-replace-efforts/> (last accessed Feb. 18, 2018) (Figure 7).

² See Jonathan Easley, *Poll: Majority Supports Single-Payer Health Care*, THE HILL, Sept. 22, 2017, available at <http://thehill.com/policy/healthcare/351928-poll-majority-supports-single-payer-healthcare> (last accessed Feb. 12, 2018).

³ See Nicholas Bagley and Eli Savit, *Michigan's Discriminatory Work Requirements*, N.Y. TIMES, May 8, 2018, available at <https://www.nytimes.com/2018/05/08/opinion/michigan-medicaid-work-requirement.html> (last accessed May 15, 2018) (“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.”).

⁴ See Aaron Blake, *Medicaid Work Requirements Are One of the Least Politically Controversial Things Trump Has Done*, WASH. POST, Jan. 11, 2018, available at 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.

⁵ See Walker Ray and Tim Norbeck, *Healthcare Is Turning Into an Industry Focused on Compliance, Regulation Rather than Patient Care*, FORBES, Nov. 5, 2013, available at <https://www.forbes.com/sites/physiciansfoundation/2013/11/05/healthcare-is-turing-into-an-industry-focused-on-compliance-regulation-rather-than-patient-care/#3c75d6962e3c> (last accessed Feb. 16, 2018) (“[The ACA] hastened the growth of a mega-trillion dollar industry that seems more interested in advanced technology, federal regulation and personal data collection, than in the doctor’s care and life-saving treatment of patients”). See also *Over-Regulated America*, THE ECONOMIST,

economical health care access to 65-year-olds, but charges 64-year-olds \$21,000 for a diagnosis of indigestion.⁶ Increasingly and alarmingly, it provides coverage for those living in poverty, but—inexplicably—imposes premiums on them.⁷

As a result, a conflicting and counterintuitive regulatory scaffolding dominates the landscape, haunted by the adept illustration, described through the words of James Kwak, that “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.”⁸ Health care in America is *both* a universal human right,⁹ a moral cause,¹⁰ a foundation for

Feb. 18, 2012, *available at* <http://www.economist.com/node/21547789> (“America is meant to be the home of laissez-faire.”).

⁶ See Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013, at 4 (“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.”).

⁷ See MaryBeth Musumeci, et al., *Approved Changes in Indiana’s Section 1115 Medicaid Waiver Extension*, KAISER FAMILY FOUNDATION, Feb. 9, 2018, *available at* <https://www.kff.org/medicaid/issue-brief/approved-changes-in-indianas-section-1115-medicaid-waiver-extension/> (last accessed Apr. 20, 2018) (noting that “Monthly premiums apply to all beneficiaries from 0-138 percent FPL based on income and are at least \$1.00”). Premiums are “tiered” in that individuals making less than 22 percent of FPL (monthly income ranges from \$0 to \$223 per month) are charged \$1.00 per month, whereas individuals making between 23 percent and 50 percent of FPL (monthly income ranges from \$223 to \$506 per month) are charged \$5.00 per month).

⁸ *The Problem with Obamacare*, THE BASELINE SCENARIO, May 9, 2016, *available at* <https://baselinescenario.com/2016/05/09/the-problem-with-obamacare/> (last accessed Feb. 8, 2018) (“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.”).

⁹ See Matt Taibbi, *Finally Everyone Agrees: Health Care Is a Human Right*, ROLLING STONE, June 30, 2017, *available at* <https://www.rollingstone.com/politics/news/taibbi-finally-everyone-agrees-health-care-is-a-human-right-w490605> (last accessed Feb. 17, 2018).

¹⁰ See Jack Craver, *Most Americans View Health Care as A Moral Issue*, BENEFITSPRO, Sept. 9, 2015, *available at* <http://www.benefitspro.com/2015/09/09/most-americans-view-health-care-as-moral-issue> (last accessed Feb. 17, 2018); Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 672 (2003) (“Moral fairness requires equity and just distribution of societal goods and would forbid abandonment of the sick and disabled.”).

human flourishing,¹¹ and it is a consumer good,¹² a risk pool,¹³ a deductible.¹⁴

Discordant policies bloom from capricious soil. America (still) does not provide health insurance for all, but requires hospitals to treat all, without regard to ability to pay, in an emergency.¹⁵ Impoverished citizens receive health insurance through the state's Medicaid program—assuming they are adequately impoverished—but only for those belonging to one of the fortified categories making up the “deserving poor.”¹⁶ America incentivizes insurance companies' participation in individual and private employer marketplaces¹⁷ by

¹¹ See Atul Gawande, *Is Health Care a Right?*, THE NEW YORKER, Oct. 2, 2017, available at <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”).

¹² See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contract, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 7 (1999) (presenting the argument that “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) (noting that “[m]any believe that health care is, or should be treated as, a ‘typical’ economic good”).

¹³ *What Are “High-Risk Pools” and Do They Lower Health Care Costs?*, NPR, May 6, 2017, available at <https://www.npr.org/2017/05/06/527140030/what-are-high-risk-pools-and-do-they-lower-health-care-costs> (last accessed Feb. 14, 2018).

¹⁴ See Russell Korobkin, *Health-Care Costs and the “Moral Hazard” Problem*, WASH. POST, Mar. 10, 2014, available at https://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/03/10/health-care-costs-and-the-moral-hazard-problem/?utm_term=.88c212bf2380 (last accessed Feb. 15, 2017).

¹⁵ See *Emergency Medical Treatment Act and Labor Act (EMTALA)*, CTRS. FOR MEDICARE AND MEDICAID SERVS., Mar. 26, 2012, available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/> (last accessed Feb. 17, 2018).

¹⁶ See Annie Lowrey, *The People Left Behind When Only the “Deserving” Poor Get Help*, ATLANTIC, May 25, 2017, available at <https://www.theatlantic.com/business/archive/2017/05/the-people-who-are-left-behind-when-only-the-deserving-poor-get-help/528018/> (last accessed Feb. 15, 2018).

¹⁷ See, e.g., Katie Zernike, *The Hidden Subsidy That Helps Pay for Health Insurance*, N.Y. TIMES, Jul. 7, 2017, available at <https://www.nytimes.com/2017/07/07/health/health-insurance-tax-deduction.html> (last accessed Feb. 12, 2018) (noting that tax breaks for employer-sponsored insurance “costs the federal government \$250 billion in lost tax revenue every year,” and that “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”); *Health Insurance Marketplace Calculator*, KAISER FAMILY FOUNDATION, Nov. 3, 2017, available at <https://www.kff.org/interactive/subsidy-calculator/> (last accessed Feb. 17, 2018).

heavily subsidizing them with public funds.¹⁸ It genetically engineers an artificial market by propping up *both* buyers and sellers.¹⁹

In an ultimate transformative opportunity in 2010, America recommitted itself to the dichotomy in the individual marketplace.²⁰ The Patient Protection and Affordable Care Act of 2010 (ACA) *both* 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.²¹ 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.²² Americans now have health *insurance*, but they cannot afford health *care*.²³

But this is nothing new. America's conflictual health policy development has followed a simple pattern: the legislative solutions that have nobly but languidly expanded access have been short on devising solutions designed to contain the costs of—or, more directly,

¹⁸ *Id.* See also Bernadette Fernandez, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*, CONG. RESEARCH SERV., Feb. 10, 2017, at 9, available at <https://fas.org/sgp/crs/misc/R44425.pdf> (last accessed Feb. 17, 2018) (“For tax year 2014, approximately 3.4 million tax returns indicated receipt of advance payments of the ACA tax credits, totaling to almost \$12 billion.”).

¹⁹ 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.

²⁰ See Abbe R. Gluck and Nicole Huberfeld, *What is Federalism in Health Care For?*, 70 STAN. L. REV. __ (forthcoming, 2018) (“Despite being a major federal intervention in health policy, the ACA perpetuated and entrenched the fragmentation of American health care by expanding the various and very differently structured health care programs already in existence”).

²¹ See Sam Baker, *How the Authors of Obamacare Protected Insurance Companies*, ATLANTIC, Nov. 10, 2013, available at <https://www.theatlantic.com/politics/archive/2013/11/how-the-authors-of-obamacare-protected-insurance-companies/440853/> (last accessed Feb. 18, 2018); Bertha Coombs, *As Obamacare Twists in Political Winds, Top Insurers Made \$6 Billion (Not That There Is Anything Wrong With That)*, CNBC, Aug. 5, 2017, available at <https://www.cnbc.com/2017/08/05/top-health-insurers-profit-surge-29-percent-to-6-billion-dollars.html> (last accessed Mar. 29, 2018).

²² See Kaiser Calculator Now Gives Consumers 2015 Zip Code-Specific Premium and Tax Credit Estimates for Marketplace Coverage, KAISER FAMILY FOUNDATION, Nov. 13, 2014, available at <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/> (last accessed Feb. 17, 2018).

²³ See Helaine Olen, *Even the Insured Often Can't Afford Their Medical Bills*, THE ATLANTIC, Jun. 18, 2017, available at <https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/> (last accessed May 2, 2018). See e.g., Abby Goodnough, *As Some Got Free Health Care, Gwen Got Squeezed: An Obamacare Dilemma*, N.Y. TIMES, Feb. 19, 2018, available at <https://www.nytimes.com/2018/02/19/health/obamacare-premiums-medicaid.html> (last accessed Apr. 9, 2018).

pay for²⁴—those gains in access. No example of America’s health care contradiction is more apt than the conspicuously named Affordable Care Act,²⁵ a law that guarantees access to millions more Americans, but does little to make the cost of health care any more affordable to the citizenry. Cost-efficiency tools that could have been activated were left on the cutting room floor.²⁶

So, as it seemingly always has, a fragile hybridity saturates American health care; it is *both, simultaneously* the best of times *and* the worst of times.²⁷ Ultimately, through the reform push, a fragile balance between these two conflicted visions of health care was struck, and the ACA was born. These warring interests—in both expanding access and fighting to maintain a private and competitive market—both complicated the skeleton of the ACA and hamstrung the political sustainability of many of the reforms the ACA has attempted. A federal government moving toward universality had to pay for it by avoiding any real attempts at cost control.²⁸ To achieve the *public* goals, the regime had to rely on *private* means.²⁹ The cost of public universality is the price of private boon.

The result of contradictory federal interests and values—and state values and interests—obfuscates the role of law. Inconsistent visions make for tangled statutes and a confused populace, ultimately tainting the political process.³⁰ And an indolent Congress has worsened

²⁴ 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.”).

²⁵ “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, Spr. 2018, at 24.

²⁶ See, *infra* discussion and accompanying notes, nn. 57-58.

²⁷ CHARLES DICKENS, *A TALE OF TWO CITIES* (Chapman & Hall, 1859).

²⁸ See Jerome Groopman and Pamela Hartzband, *Putting Profits Ahead of Patients*, N.Y. REVIEW OF BOOKS, July 13, 2017, available at <http://www.nybooks.com/articles/2017/07/13/putting-profits-ahead-of-patients/> (last accessed Jun. 27, 2018) (“Obamacare put no controls on the pricing of drugs or clinical care, leaving the profit-driven health industry mostly intact”).

²⁹ Indeed, the public program of Medicaid absorbed many of the insurance access gains through the ACA. By 2016, approximately 15 million Americans had gained health insurance through Medicaid expansion. See *Interactive Maps: Estimates of Enrollment in ACA Marketplaces and Medicaid Expansion*, KAISER FAMILY FOUNDATION, Oct. 4, 2017, available at <https://www.kff.org/interactive/interactive-maps-estimates-of-enrollment-in-aca-marketplaces-and-medicaid-expansion/> (last accessed May 21, 2018).

³⁰ See Steven M. Teles, *Kludgeocracy in America*, NATIONAL AFFAIRS, Fall 2013, available at <https://www.nationalaffairs.com/publications/detail/kludgeocracy-in-america> (last accessed Jun. 27, 2018) (“The complexity and incoherence of our government often

the problem; no serious legislative solutions emanate from Capitol Hill while markets sputter and citizens struggle.³¹

Fidelity to two conflicted visions of a societal good may be common in a democratic society, but building those tensions into law and policy creates unsustainable solutions to complicated challenges. As the health care Rubik's cube has—for the moment—survived the direct frontal assault of repeal and replace,³² it nonetheless continues to face the real threat of disintegration. The technocrats' policy designs of the ACA—particularly regarding its most prominent creation of the individual marketplace—have resulted in a deeply fragmented and precarious mantel, one uniquely susceptible to regulatory sabotage approaching intramural “synthetic repeal.”³³ With few cost control tools baked into the final version of the ACA, private insurance companies now hold the keys to the kingdom; unsurprisingly, the enduring threat to American health care—its cost—continues to persist, further weakening the political commitment to the law, which emboldens those trying to destroy it.³⁴ These challenges reveal an

make it difficult for us to understand just what the government is doing... ‘Clumsy but temporarily effective’ also describes much of American public policy today.”).

By February of 2017, 35 percent of Americans did not know that “Obamacare” and the “Affordable Care Act” were the same. See Kyle Dropp and Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES, Feb. 7, 2017, available at <https://www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html> (last accessed Feb. 17, 2018) (“When respondents were asked what would happen if Obamacare were repealed, even more people were stumped. Approximately 45 percent did not know the A.C.A. would be repealed.”).

³¹ See Ed Kilgore, *Hopes Fade that Congress Will Stabilize Obamacare*, NEW YORK, Mar. 15, 2018, available at <http://nymag.com/daily/intelligencer/2018/03/hopes-fade-that-congress-will-stabilize-obamacare.html> (last accessed Apr. 9, 2018).

³² See Erica Werner, *Obamacare Survives as GOP Concedes on Last-Gasp Repeal Try*, CHICAGO TRIBUNE, Sept. 26, 2017, available at <http://www.chicagotribune.com/news/nationworld/politics/ct-gop-health-care-bill-20170926-story.html> (last accessed Apr. 26, 2018) (“Obamacare lives on.”).

³³ Michael Hiltzik, *Trump Plots Another Backdoor Effort to Gut Obamacare's Consumer Protections*, L.A. TIMES, Oct. 9, 2017, available at <http://www.latimes.com/business/hiltzik/la-fi-hiltzik-trump-associations-obamacare-20171009-story.html> (last accessed Apr. 26, 2018).

³⁴ This is not to say that the law does not have true and invested defenders. Defenders of the law—particularly those who had been benefitted by the Medicaid expansion and the pre-existing condition discrimination exclusion—were on public display throughout the summer of 2017. See, e.g., Thomas Kaplan and Robert Pear, *House Passes Measure to Repeal and replace the Affordable Care Act*, N.Y. TIMES, May 4, 2017, available at <https://www.nytimes.com/2017/05/04/us/politics/health-care-bill-vote.html> (last accessed May 3, 2018) (“Doctors, hospitals and other health care providers joined patient advocacy groups like the American Cancer Society and AARP in opposing the repeal bill.”); Michael Hiltzik, *Repealing Obamacare Could Be a Matter of Life or Death for Many Americans. Here are Their Voices*, L.A.

undeniable truth: the ACA was a tool primarily focused on securing increased opportunities for individuals to *access* health *insurance*; it was not primarily focused on making health *care* *affordable*, and thus guaranteeing *secure access to care* to its populace.

By prioritizing universal access to health insurance—improving transparency and competition, placing millions into the market and onto the exchanges, and expanding the Medicaid program to cover millions more Americans—the ACA clearly changed the prevailing thinking regarding health insurance access in the United States. But, by failing to link that access to policies that adequately address the cost crisis facing American health care—to actually spend as much regulatory energy on the *cost* of the \$629 Band-Aid as it did on premium assistance tax subsidies, for example³⁵—the ACA’s sustainability is only as strong as its ability to relentlessly shield Americans from the cost of their own health care. With health care expenditures growing faster than Americans’ paychecks and a president hostile to its survival,³⁶ the ACA’s shields are likely to crack for more and more citizens.³⁷ As a result, in 2018, its sparkling access gains are precariously wobbly.³⁸

This article will proceed in four parts. In Part I, the two major component parts of health policy within the ACA—both the law’s

TIMES, Jan. 9, 2017, *available at* <http://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-voices-20170109-story.html> (last accessed May 3, 2018).

³⁵ See Sarah Kliff, *The Case of the \$629 Band-Aid—And What It Reveals About American Health Care*, VOX, May 13, 2016, *available at* <https://www.vox.com/2016/5/13/11606760/emergency-facility-fees-american-health-care> (last accessed Apr. 26, 2018).

³⁶ See Jay Hancock and Shefali Luthra, *High Deductibles Are Forcing Employees to Pay Moore Money Out of Pocket*, TIME, Sept. 15, 2016, *available at* <http://time.com/money/4494938/high-deductible-health-plans-employee-costs/> (last accessed May 2, 2018) (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 percent during that same period from 2011 to 2016. *Id.* See also Thomas Kaplan, “Let Obamacare Fail,” *Trump Says As G.O.P. Health Bill Collapses*, N.Y. TIMES, Jul. 18, 2017, *available at* <https://www.nytimes.com/2017/07/18/us/politics/republicans-obamacare-repeal-now-replace-later.html> (last accessed Jul. 30, 2018) (noting that President “declared that his plan was now to ‘let Obamacare fail’”).

³⁷ See, e.g., Olen, *supra* note 23 (“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.”).

³⁸ It seems as though the insurance rate may have already reached a high-water mark, with the number of insured Americans likely to drop in 2019. See Tami Luhby, *Nine Million Fewer Americans Expected to Have Health Insurance in 2019*, CNN, *available at* <http://money.cnn.com/2018/02/26/news/economy/obamacare-trump-insurance/index.html> (last accessed May 6, 2018).

access success and its persistent cost challenge—will be explored. In Part II, the federal government’s chosen course of private regulation—in both subsidizing the market and its consumers—will be reviewed. The ACA’s reliance on structural—and not sustainable—access will be sketched, which has notably differed from other social good programs. In Part III, enduring challenges to the ACA’s subsidy approach—both economic and political—will be highlighted. And, finally, in Part IV, a paradigmatic shift in thinking will be sketched.

I. A TALE OF TWO ACAS

Now more than eight years after the passage of the ACA, it is clear that the law established important insurance protections and built a platform for accomplishing expansive health insurance coverage for a populace that has long craved it.³⁹ But it also did little to fundamentally alter the health care financing system, or to “bend the cost curve.”⁴⁰ As designed, the ACA places predominant importance on assisting—through bolstering public financing and activating consumer-based tools—individuals in their efforts to acquire access to high-quality health insurance. It has reformed nearly every corner of health care delivery in the name of access to that health insurance. However, now—to muddy that picture considerably—the ACA’s external layers are rapidly disintegrating.⁴¹

³⁹ 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*, THE ATLANTIC, Jul. 14, 2017, available at <https://www.theatlantic.com/health/archive/2017/07/us-worst-health-care-commonwealth-2017-report/533634/> (last accessed Jan. 6, 2018) (“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.”).

⁴⁰ *NHE Fact Sheet*, CENTERS FOR MEDICARE & MEDICAID SERVICES, CMS.gov, Dec. 6, 2017, available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last accessed Jan. 5, 2018) (noting that national health expenditures amounted to \$10,348 per person in 2016 and that out of pocket spending increased nearly four percent, to more than \$350 billion annually). See also Ester Bloom, *Here’s How Much the Average American Spends on Health Care*, CNBC, Jun. 23, 2017, available at <https://www.cnbc.com/2017/06/23/heres-how-much-the-average-american-spends-on-health-care.html> (last accessed Jan. 5, 2018) (“Indeed, average annual costs per person hit \$10,345 in 2016. In 1960, the average cost per person was only \$146—and, adjusting for inflation, that means costs are nine times higher now than they were then.”).

⁴¹ See, e.g., Robert Pear, Maggie Haberman, and Reed Abelson, *Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again*, N.Y. TIMES, Oct. 12, 2017, available at https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-insurance.html?_r=0 (last accessed Jan. 6, 2018) (“Without the subsidies, insurance markets could quickly unravel.”); Margot Sanger-Katz, *Requiem for the Individual Mandate*, N.Y. TIMES, Dec. 21, 2017, available at

It has also grown beyond its borders into both an enduring political target⁴² and an ill-defined and shadowy unknown,⁴³ like a regulatory “mythical beast.”⁴⁴ Peculiarly, its most sympathetic public defender has been a late-night comedian who made his name hosting *The Man Show*,⁴⁵ indispensably informing sleepy-eyed Americans of what the law actually does.⁴⁶ Because it has become all things to many, the ACA has become a modern legislative embodiment of a piece of abstract art: to some, the law is not saving any lives,⁴⁷ has likely worsened the opioid crisis,⁴⁸ and has not lessened or prevented medical bankruptcies.⁴⁹ But other prominent voices see in its contours that it

<https://www.nytimes.com/2017/12/21/upshot/individual-health-insurance-mandate-end-impact.html> (last accessed Jan. 5, 2018) [*hereinafter*, *Requiem*] (“The individual mandate, an idea inspired by conservative intellectuals but ultimately embraced by Democratic lawmakers as an essential part of the Affordable Care Act, will soon be dead. The provision would be eliminated under the tax bill passed on Wednesday.”); Margot Sanger-Katz, *A Big Divergence Is Coming in Health Care Among States*, N.Y. TIMES, Feb. 28, 2018, available at <https://www.nytimes.com/2018/02/28/upshot/health-care-obamacare-states-divergence.html> [*hereinafter*, *A Big Divergence*] (last accessed May 21, 2018) (“The result is likely to be big differences in health insurance options and coverage, depending on where you live.”).

⁴² See Robert Pear, *Years of Attack Leave Obamacare a More Government-Focused Health Law*, N.Y. TIMES, Dec. 26, 2017, available at <https://www.nytimes.com/2017/12/26/us/politics/republicans-trump-affordable-care-act-obamacare.html> (last accessed Apr. 17, 2018).

⁴³ See Dropp and Nyhan, *supra* note 29 (noting that “only 61 percent of adults knew that many people would lose coverage through Medicaid or subsidies for provide health insurance if the A.C.A. were repealed and no replacement enacted”).

⁴⁴ Michael Hiltzik, *Seeing the Positive Changes Brought by the Federal Health Law*, CHICAGO TRIBUNE, Dec. 29, 2013, available at <http://www.chicagotribune.com/la-fi-hiltzik-20131224-column.html> (last accessed Apr. 16, 2018) (“And many blame this curious, largely mythical beast called Obamacare”).

⁴⁵ See Megan Garber, *Forgiving Jimmy Kimmel*, THE ATLANTIC, Mar. 2, 2018, available at <https://www.theatlantic.com/entertainment/archive/2018/03/forgiving-jimmy-kimmel/554675/> (last accessed May 3, 2018).

⁴⁶ See Laura Gambino, *Jimmy Kimmel: TV Host Emerges As Unlikely Leader in Fight to Save Obamacare*, GUARDIAN, Sept. 21, 2017, available at <https://www.theguardian.com/us-news/2017/sep/21/jimmy-kimmel-tv-host-republicans-obamacare-health> (last accessed Apr. 18, 2018).

⁴⁷ See Ross Douthat, *Is Obamacare a Lifesaver?*, Opinion, N.Y. TIMES, Mar. 29, 2017, available at <https://www.nytimes.com/2017/03/29/opinion/is-obamacare-a-lifesaver.html> (last accessed Mar. 29, 2018).

⁴⁸ See *id.*

⁴⁹ See Megan McArdle, *The Truth about Medical Bankruptcies*, WASH. POST, Mar. 26, 2018, available at https://www.washingtonpost.com/blogs/post-partisan/wp/2018/03/26/the-truth-about-medical-bankruptcies/?utm_term=.e47a3f20e562 (last accessed Mar. 29, 2018).

has saved lives,⁵⁰ it is fighting the opioid crisis,⁵¹ and is reducing medical bankruptcies.⁵² It has become the most recent illustration of our conflicted and fragmented health care delivery system, mirroring our intractably divided politics.

This is not to say that all of its outcomes are hopelessly abstruse. Admirably, 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 1965.⁵³ Millions of Americans—particularly, *sick* Americans—have gained access to health insurance in the biggest expansion of insurance coverage in two generations. Norms around who deserves health insurance access have clearly shifted.⁵⁴ “Preexisting condition” has become a term firmly ensconced in public discourse.⁵⁵

⁵⁰ See, e.g., *Obamacare Saved Thousands from Colon Cancer Death, Report Finds*, NBC NEWS, Jan. 23, 2017, available at <https://www.nbcnews.com/health/cancer/obamacare-saved-thousands-colon-cancer-death-report-finds-n710951> (last accessed Mar. 28, 2018).

⁵¹ See Keith Humphreys, *No, Obamacare's Medicaid Expansion Did Not Cause the Opioid Crisis*, WONKBLOG, WASH. POST, Jan. 23, 2018, available at https://www.washingtonpost.com/news/wonk/wp/2018/01/23/no-obamacares-medicaid-expansion-did-not-cause-the-opioid-crisis/?utm_term=.e669555b09e3 (last accessed Mar. 29, 2018).

⁵² See Michael Hiltzik, *Another Little-Mentioned Benefit of Obamacare: It Has Reduced Medical Bankruptcies*, Opinion, L.A. TIMES, May 9, 2017, available at <http://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-bankruptcy-20170509-story.html> (last accessed Mar. 29, 2018); Vann R. Newkirk II, *The American Health-Care System Increases Income Inequality*, THE ATLANTIC, Jan. 19, 2018, available at <https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/> (last accessed Jun. 25, 2018) (“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.”).

⁵³ 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.”).

⁵⁴ See Kristen Bialik, *More Americans Say Government Should Ensure Health Care Coverage*, PEW RESEARCH CENTER, Jan. 13, 2017, available at <http://www.pewresearch.org/fact-tank/2017/01/13/more-americans-say-government-should-ensure-health-care-coverage/> (last accessed Apr. 16, 2018) (“Currently, 60 percent of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38 percent who say this should not be the government’s responsibility. The share saying it is the government’s responsibility has increased from 51 percent last year and now stands at its highest point in nearly a decade.”).

⁵⁵ See Jackie Farwell, *Mainers, Here are the Basics on Pre-Existing Medical Conditions*, BANGOR DAILY NEWS, May 10, 2017, available at <http://vitalsigns.bangordailynews.com/2017/05/10/affordable-care-act/mainers-here-are-the-basics-on-pre-existing-medical-conditions/> (last accessed Apr. 16, 2018).

But, where the law vastly improved individuals' structural access to health insurance, it failed to go any deeper. It is as if the law attempted to address many of the symptoms of America's health care "non-system,"⁵⁶ but did not take on the harder task of constructing a comprehensive curative structure to fully solve all of its nagging cost problems. The ACA was sure to apply pressure and a bandage to the wound—the best bandage, in fact—but did not treat the underlying condition. Much like our fragmented health care system, it treated the *effect* but not the *cause* of America's health care virus.

That the ACA's provisions did not bring cures to what ails American medicine is unsurprising. After all, a cost-bending single-payer proposal was withdrawn in the Senate in 2009 following key opposition,⁵⁷ and a similarly cost-conscious public option was discussed, but eventually dropped.⁵⁸ As a result, although the ACA

("The term is insurance company jargon but it's quickly becoming part of the popular lexicon.").

⁵⁶ See Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, (2014) ("Health economists and policy experts place much of the responsibility for cost and quality deficiencies in health care on the fragmented nature of the American system (more accurately, 'non-system').") (citations omitted). Walter B. Maher, *Health Care in America: Implications for Business and the Economy*, 3 STAN. L. & POL'Y REV. 55, 55 (1991) ("American citizens are not well served by their country's health care system or, more accurately, nonsystem").

⁵⁷ *Single-Payer Health Care Plan Dies in Senate*, NBC NEWS, Dec. 16, 2009, available at http://www.nbcnews.com/id/34446325/ns/politics-health_care_reform/t/single-payer-health-care-plan-dies-senate/#.Wk_X8SOZNE4 (last accessed Jan. 5, 2018).

⁵⁸ See Helen A. Halpin and Peter Harbage, *The Origins and Demise of the Public Option*, HEALTH AFFAIRS, June 2010, available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0363> (last accessed Jan 5, 2018) (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*, 375 NEW ENG. J.M., Oct. 27, 2016, available at <http://www.nejm.org/doi/full/10.1056/NEJMs1612292> (last accessed Jan. 5, 2018) ("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 Obamacare?*, N.Y. TIMES, Sept. 29, 2016, available at <https://www.nytimes.com/2016/09/29/upshot/the-health-care-public-option-is-back-can-it-help-obamacare.html> (last accessed Jan. 5, 2018) (noting that in 2010, the public option "was a no-go even with Democratic control of both branches [of Congress] in 2010"); *Why Lieberman Hates the Public Option*, THE ATLANTIC, Oct. 28, 2009, available at <https://www.theatlantic.com/politics/archive/2009/10/why-lieberman-hates-the-public-option/347740/> (last accessed Apr. 26, 2018) ("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, or 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*, THE

addressed some of its worst immediate symptoms, American health care in 2018 still suffers from a noxious mix of inefficiencies, upside-down incentives, untethered and irrational pricing, and impotent regulation, largely because ready-made structural solutions have not been sufficiently deployed to bring down the cost of services and products on which Americans depend to lead productive and lengthy lives. A further study highlighting this contradiction—of its successful access reforms and its ineffective, or simply nonexistent, cost control efforts—follows immediately below.

A. *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”⁵⁹ 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 passage⁶⁰—said “[t]oday we have the opportunity to complete the great unfinished business of our country.”⁶¹ Indeed, as has been said, it may have been “the most important event of the Obama presidency.”⁶²

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.⁶³ In a statement striking for its multiple *post hoc* translations—perhaps both conveying the gravity of the moment, and lamentedly recognizing the incremental nature of its reform—Obama noted that “[t]his is what change looks like.”⁶⁴ Vice President Joe Biden was less measured, but surely more colorful.⁶⁵

HILL, Feb. 10, 2016, *available at* <http://thehill.com/policy/healthcare/268877-the-chaotic-fight-for-obamacare> (last accessed May 6, 2018).

⁵⁹ See FRANCIS FUKUYAMA, *THE END OF HISTORY AND THE LAST MAN* (The Free Press, 1992).

⁶⁰ See Cusack, *supra* note 58.

⁶¹ See Karen Tumulty, *Making History: House Passes Health Care Reform*, TIME, Mar. 23, 2010, *available at* <http://content.time.com/time/politics/article/0,8599,1973989,00.html> (last accessed Apr. 5, 2018).

⁶² See David Blumenthal, *The Affordable Care Act at Five Years*, 372 NEW ENG. J. MED. 2451 (June 18, 2015), *available at* <http://www.nejm.org/doi/full/10.1056/NEJMp1503614> (last accessed Apr. 15, 2018).

⁶³ See Tumulty, *supra* note 61.

⁶⁴ *Id.* Ewen MacAskill, *Barack Obama’s Healthcare Bill Passed by Congress*, THE GUARDIAN, Mar. 22, 2010, *available at* <https://www.theguardian.com/world/2010/mar/22/us-healthcare-bill-passes-congress> (last accessed Apr. 5, 2018).

⁶⁵ See Brian Montopoli, *Biden Swears at Bill Signing: Just Biden Being Biden?*, CBS NEWS, Mar. 23, 2010, *available at* <https://www.cbsnews.com/news/biden-swears-at-bill-signing-just-biden-being->

And regarding structural access, Biden was right: the ACA has been a game-changer. It has ushered in rapid changes to America's complicated and complex health insurance system. Millions of Americans have gained access to insurance through massive expansions, 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.⁶⁶ The law has been "surprisingly resilient,"⁶⁷ perhaps most tellingly on this score of health care insurance coverage, even after regulatory changes brought about by the Trump administration shrunk the number of insured Americans⁶⁸ and made health insurance both more expensive and harder to find.⁶⁹ Recent proposals seek to continue this trend.⁷⁰

On perhaps its most important metric, by just the third year of the ACA's implementation, the American uninsurance rate had

biden/ (last accessed Apr. 10, 2018) (describing Vice President Biden as telling President Obama that "passage of the bill is a 'big fucking deal'").

⁶⁶ See John Ydstie, *How the Affordable Care Act Pays for Insurance Subsidies*, NPR, Nov. 7, 2013, available at <https://www.npr.org/sections/health-shots/2013/11/07/243584170/how-the-affordable-care-act-pays-for-insurance-subsidies> (last accessed Jun. 27, 2018); Linda Qiu, *Calling Cost-Sharing Reduction Payments 'a Bailout' Is Misleading*, N.Y. TIMES, Oct. 18, 2017, available at <https://www.nytimes.com/2017/10/18/us/politics/cost-sharing-reductions-bailout.html> (last accessed Jun. 27, 2018).

⁶⁷ Peter Sullivan, *ObamaCare Proves Surprisingly Resilient*, THE HILL, Dec. 25, 2017, available at <http://thehill.com/policy/healthcare/366239-obamacare-proves-surprisingly-resilient> (last accessed Apr. 15, 2018). See also Harold Pollack, *Republicans Couldn't Kill Obamacare. That's the Genius of its Design.*, WASH. POST, Mar. 29, 2017, available at https://www.washingtonpost.com/posteverything/wp/2017/03/29/republicans-couldnt-kill-obamacare-thats-the-genius-of-its-design/?utm_term=.d421a6699c6d (last accessed Apr. 15, 2018) ("And in doing so, it has quietly embedded itself within the fabric of American life—and has become very difficult for politicians to kill.").

⁶⁸ Nonetheless, the changes were not as impactful as originally feared. See *National ACA Marketplace Signups Dipped a Modest 3.7 Percent This Year*, KAISER FAMILY FOUNDATION, Feb. 7, 2018, available at <https://www.kff.org/health-reform/press-release/national-aca-marketplace-signups-dipped-a-modest-3-7-percent-this-year/> (last accessed May 2, 2018).

⁶⁹ *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").

⁷⁰ See Sanger-Katz, *A Big Divergence*, *supra* note 41 ("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.").

dropped to 10.3 percent of the U.S. population.⁷¹ 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 hovered between 16 and 18 percent of the population.⁷² In a country of more than 320 million, a reduction of the uninsurance rate by about 40 percent is no small feat. In an access battle that had been fought for generations,⁷³ the ACA made real headway.

Of course, most of the heavy lifting was accomplished by the relentlessly battered⁷⁴ Medicaid program. By April of 2018, 32 states and the District of Columbia—a high-water mark—had expanded their workhorse Medicaid programs under the ACA,⁷⁵ additionally insuring a total of more than 11 million beneficiaries.⁷⁶ In total, largely driven by its expansion under the ACA, by December 2017, Medicaid covered approximately 74 million beneficiaries—up from about 57 million before the ACA passed.⁷⁷ More than 20 percent of Americans get insurance through Medicaid, and, with holdout states still considering Medicaid expansion, this number may yet grow in the near future.⁷⁸

⁷¹ *Key Facts about the Uninsured Population*, KAISER FAMILY FOUNDATION, Nov. 29, 2017, available at <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> (last accessed Mar. 29, 2018) (this uninsurance rate amounts to about 28 million people).

⁷² *Id.*

⁷³ 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 AND CHIP PAYMENT AND ACCESS COMMISSION*, available at <https://www.macpac.gov/medicaid-101/eligibility/> (last accessed May 2, 2018) (“Between 1984 and 1990, however, Congress made a number of changes that expanded Medicaid for pregnant women and children.”).

⁷⁴ 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 FAMILY FOUNDATION, Mar. 15, 2017, available at <https://www.kff.org/medicaid/issue-brief/restructuring-medicaid-in-the-american-health-care-act-five-key-considerations/> (last accessed Apr. 16, 2018).

⁷⁵ *States of State Action on the Medicaid Expansion Decision*, KAISER FAMILY FOUNDATION, Apr. 5, 2018, available at <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> (last accessed Apr. 14, 2018).

⁷⁶ *See* Leighton Ku, Julia Paradise, and Victoria Thompson, *Data Note: Medicaid's Role in Providing Access to Preventive Care for Adults*, KAISER FAMILY FOUNDATION, May 17, 2017, available at <https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/> (last accessed Apr. 16, 2018).

⁷⁷ *Total Monthly Medicaid and CHIP Enrollment*, KAISER FAMILY FOUNDATION, Dec. 2017, available at <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> (last accessed Mar. 29, 2018). In sum, the

⁷⁸ *See* Joel Ebert and Dave Boucher, *Behind Closed Doors, Haslam Asks Again: Can Tennessee Expand Health Care for Working Poor?*, TENNESSEAN, Apr.

Expanding coverage for the Medicaid population is likely to translate into increases in the amount of individuals receiving preventive care.⁷⁹

Undoubtedly, 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 percent before the implementation of the ACA to 6.8 percent during the middle of 2017.⁸⁰ In a state of nearly 40 million people, that means that more than four million people have gained health insurance in just the last five years in the state.⁸¹ In another example, after the first few years of the ACA, Illinois’ uninsured population had shrunk from 1.6 million to just 817,000.⁸² By the end of 2014, a striking chart in the NEW YORK TIMES illustrated the insurance access gains in different parts of the country, with large swaths of Oregon, Nevada, New Mexico, southern Colorado, southwest Texas, and Arkansas showing more than a 10 percent jump in health insurance rates in those regions.⁸³

In addition to widening access to health insurance, the ACA also deepened health insurance coverage. Specifically, the ACA made preventive care and chronic disease treatment—in addition to a number

13, 2018, available at <https://www.tennessean.com/story/news/politics/2018/04/13/can-tennessee-expand-health-care-working-poor-haslam-asks-behind-closed-doors/511878002/> (last accessed Apr. 14, 2018); Mallory Noe-Payne, *Medicaid Expansion in Virginia Inches Closer to Reality*, WVTF, Apr. 6, 2018, available at <http://wvtf.org/post/medicaid-expansion-virginia-inches-closer-reality> (last accessed Apr. 16, 2018).

⁷⁹ See Miguel Marino et al., *Receipt of Preventive Services After Oregon’s Randomized Medicaid Experiment*, 50 AM. J. PREV. MED. 161 (Feb. 2016) (“this 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”).

⁸⁰ See Cathie Anderson, *California’s Uninsured Rate Drops to New Low*, SACRAMENTO BEE, Nov. 21, 2017, available at <http://www.sacbee.com/news/local/health-and-medicine/article185812078.html> (last accessed Apr. 6, 2018).

⁸¹ *California Population Grows by 300K, Nears 40 Million*, CBS LOS ANGELES, Dec. 22, 2017, available at <http://losangeles.cbslocal.com/2017/12/22/california-population-nears-40-million/> (last accessed Apr. 5, 2018).

⁸² See Lisa Schencker, *Illinois Uninsured Rate Falls Again – But For How Long?*, CHICAGO TRIBUNE, Sept. 12, 2017, available at <http://www.chicagotribune.com/business/ct-health-insurance-coverage-increases-0913-biz-20170912-story.html> (last accessed Apr. 5, 2018).

⁸³ See Kevin Quealy and Margot Sanger-Katz, *Obama’s Health Law: Who Was Helped Most*, N.Y. TIMES, Oct. 29, 2014, available at <https://www.nytimes.com/interactive/2014/10/29/upshot/obamacare-who-was-helped-most.html?action=click&contentCollection=The%20Upshot®ion=Footer&module=WhatsNext&version=WhatsNext&contentID=WhatsNext&moduleDetail=undefined&pgtype=Multimedia> (last accessed Apr. 5, 2018).

of other treatments—available to millions of Americans.⁸⁴ 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.⁸⁵

Finally, 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,⁸⁶ outlawed preexisting conditions,⁸⁷ and banned medical underwriting.⁸⁸ In a noteworthy regulatory provision, the ACA also strictly limited the profits that health insurance companies can pocket on the exchanges through medical-loss ratio regulations.⁸⁹

B. Merciless Cost Expenditure Growth

It is an exhaustingly well-worn refrain by now: American health care is too expensive.⁹⁰ The country spends \$3.3 trillion annually on health care, which amounts to \$10,348 per person.⁹¹ It now

⁸⁴ *Key Facts about the Uninsured Population*, *supra* note 71.

⁸⁵ *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, KAISER FAMILY FOUNDATION, Aug. 4, 2015, available at <https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/> (last accessed Apr. 16, 2018).

⁸⁶ *Lifetime & Annual Limits*, HEALTH AND HUMAN SERVICES, HHS.GOV, Jan. 31, 2017, available at <https://www.hhs.gov/healthcare/about-the-aca/benefit-limits/index.html> (last accessed Apr. 16, 2018).

⁸⁷ *Pre-Existing Conditions*, HEALTH AND HUMAN SERVICES, HHS.GOV, Jan. 31, 2017, available at <https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html> (last accessed Apr. 16, 2018).

⁸⁸ Gary Claxton et al., *Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, KAISER FAMILY FOUNDATION, Dec. 12, 2016, available at <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/> (last accessed Apr. 16, 2018) (“Prior to 2014 medical underwriting was permitted in the individual insurance market in 45 states and DC.”).

⁸⁹ *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, KAISER FAMILY FOUNDATION, Feb. 29, 2012, available at <https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/> (last accessed Apr. 16, 2018).

⁹⁰ Recent work has suggested that America’s health care cost spending became anomalous – as compared to other countries – starting in 1980. See Austin Frakt, *Medical Mystery: Something Happened to U.S. Health Spending After 1980*, N.Y. TIMES, May 14, 2018, available at <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> (last accessed May 16, 2018).

⁹¹ See Historical National Health Expenditure Data, CENTERS FOR MEDICARE AND MEDICAID SERVICES, Jan. 8, 2018, available at <https://www.cms.gov/Research->

accounts for 18 percent of the Gross Domestic Product (GDP).⁹² And it will continue to grow in stature: American health expenditures are forecasted to hit \$5.7 trillion, and nearly 20 percent of the GDP, by 2026.⁹³ But beyond facts and figures lacking context, what illustrates why American health care is too expensive, of course, is the comparative data.

And, undoubtedly, those data are damning. Switzerland, the second-highest-spending country, allocates \$7,919 per person annually on health care.⁹⁴ Third-place Germany spends just over \$5,500—roughly *half* of what the United States spends.⁹⁵ The United Kingdom spends only \$4,200 annually; the “comparable country average” of other first-world countries surveyed totals around \$5,200.⁹⁶ Certainly, the trends are worsening; the United States’ gap in health care spending—between it and every other country—has precipitously widened over the last 50 years.⁹⁷

Since it entered the stage against that backdrop in March of 2010, the ACA’s ability to positively impact the cost of American health care has been “mixed.”⁹⁸ From a global perspective, the growth of national health expenditures rose with the implementation of the ACA, and then slowed in 2016.⁹⁹ Interestingly, in 2016, both “the

Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (last accessed Apr. 18, 2018).

⁹² See Historical National Health Expenditure Data, CENTERS FOR MEDICARE AND MEDICAID SERVICES, Jan. 8, 2018, *available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last accessed Apr. 18, 2018).

⁹³ See *National Health Expenditure Projections 2017-2026*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, *available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf> (last accessed Apr. 18, 2018).

⁹⁴ See Bradley Sawyer and Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries?*, PETERSON-KAISER HEALTH SYSTEM TRACKER, Feb. 13, 2018, *available at* https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/?_sf_s=health+spending#item-start (last accessed Apr. 19, 2019).

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ See Sawyer and Cox, *supra* note 94.

⁹⁸ See Brad Tuttle, *Here’s What’s Happened to Health Care Costs in America in the Obama Years*, TIME, Oct. 4, 2016, *available at* <http://time.com/money/4503325/obama-health-care-costs-obamacare/> (last accessed Apr. 16, 2018).

⁹⁹ See Micah Hartman, *National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions*, HEALTH AFFAIRS, Dec. 6, 2017, *available at* <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1299> (last accessed Apr. 19, 2018) (showing that national health expenditures grew 4.1 percent in 2010, 3.5 percent in 2011, 4.0 percent in 2012, 2.9 percent in 2013, 5.1 percent in 2014, 5.8

federal government and households accounted for the largest shares of health care spending,” each responsible for 28 percent of overall health care expenditures.¹⁰⁰

A recently-released study has indicated that out-of-pocket expenditures dropped nearly 12 percent following the increases in insurance coverage, but that “premium contributions” increased by 12 percent.¹⁰¹ For individuals earning more than 400 percent of the federal poverty level, the study indicated a nearly 23 percent increase in premiums in the two years since ACA implementation.¹⁰² These are individuals, thanks to the ACA’s tax subsidy structure, who face the full force of any cost premium increases.

Clearly, these numbers indicate that the law has benefitted the poorest Americans—reducing their out of pocket spending by more than 21 percent—but caused “middle-income households [to see] a 28 percent jump in high-burden premium spending,”¹⁰³ 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.”¹⁰⁴ 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.”¹⁰⁵

Regarding the individual market, those signing up for health insurance on the health insurance exchange have been subject to repeated premium jumps. In Tennessee, carrier BlueCross Blue Shield requested a 62 percent average increase in 2017 and a 21 percent

percent in 2015, and 4.3 percent in 2016). The “faster growth in 2014 and 2015” was “associated with coverage expansions under the Affordable Care Act (ACA) and strong retail prescription drug spending growth.” *Id.*

¹⁰⁰ *Id.*

¹⁰¹ Anna Goldman, et al., *Out-of-Pocket Spending and Premium Contributions After Implementation of the Affordable Care Act*, J. AMER. MED. ASSN. INTERNAL MED., Mar. 2018, at 347, available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2669908> (last accessed Apr. 16, 2018).

¹⁰² See Dan Mangan, *Out-Of-Pocket Health Spending Dropped by Nearly 12 Percent – But Premiums Rose After Obamacare Roll Out*, CNBC, Jan. 22, 2018, available at <https://www.cnbc.com/2018/01/22/out-of-pocket-health-spending-dropped-after-obamacare-rolled-out.html> (last accessed Apr. 18, 2018).

In 2018, 400 percent of FPL for a family of two is approximately \$66,000 per year; for a family of four, it is about \$100,000 of annual income. See *Federal Poverty Guidelines*, Families USA, July 2018, available at <https://familiesusa.org/product/federal-poverty-guidelines> (last accessed Jul. 31, 2018).

¹⁰³ Mangan, *supra* note 102.

¹⁰⁴ *Id.*

¹⁰⁵ Toni Clarke, *U.S. Healthcare Spending Growth Slowed in 2016*, REUTERS, Dec. 6, 2017, available at <https://www.reuters.com/article/us-usa-healthcare-report/u-s-healthcare-spending-growth-slowed-in-2016-idUSKBN1E031D> (last accessed Apr. 19, 2018).

average increase in 2018.¹⁰⁶ Cigna requested a 46 percent increase in 2017 and a 42 percent increase in 2018.¹⁰⁷ A third carrier, Humana, requested a 44 percent increase in 2017, and exited the markets in 2018.¹⁰⁸

Premium increases across a number of plans in a number of states—undoubtedly impacted by regulatory and enforcement changes brought about by the Trump administration—are substantial.¹⁰⁹ For example, a carrier in Georgia requested an average rate increase of 34.5 percent, one in Maryland requested one at more than 45 percent, multiple Michigan carriers requested increases ranging from 13 to 27 percent, respectively, New Mexico’s carriers requested increases of 21 percent, 33 percent, and 49 percent, respectively, and one in Virginia requested an increase of 21.5 percent, with another requesting an increase above 54 percent.¹¹⁰ 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.”¹¹¹ Three states saw their average premiums triple from 2013 to 2017.¹¹²

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 percent in Vermont, and about 30 percent in Maryland.¹¹³ One plan in Maryland reportedly listed a 91.4 percent premium increase.¹¹⁴

Nonetheless, tax subsidies on the individual marketplace insulate the typical consumer from feeling the worst effects of those

¹⁰⁶ See Holly Fletcher, *Tennessee’s ACA Market “Even Less Secure” After Failed Repeal*, *Insurance Chief Frets*, TENNESSEAN, Jul. 28, 2017, available at <https://www.tennessean.com/story/money/industries/health-care/2017/07/28/mcpeak-questions-congressional-shore-up-aca-market-after-repeal-defeat/520001001/> (last accessed Apr. 26, 2018).

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ See Rabah Kamal et al., *An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges*, KAISER FAMILY FOUNDATION, Aug. 10, 2017, available at <https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/> (last accessed Apr. 26, 2018).

¹¹⁰ *Id.*

¹¹¹ See HHS Report: *Average Health Insurance Premiums Doubled Since 2013*, U.S. DEP’T. HEALTH AND HUMAN SERVS., May 23, 2017, available at <https://www.hhs.gov/about/news/2017/05/23/hhs-report-average-health-insurance-premiums-doubled-2013.html> (last accessed Apr. 26, 2018).

¹¹² *Id.* (the three states were Alaska, Alabama, and Oklahoma, according to the Department of Health and Human Services).

¹¹³ Catherine Rampell, *Column, This is What a Death Spiral Looks Like*, WASH. POST, May 14, 2018, available at https://www.washingtonpost.com/opinions/this-is-what-a-death-spiral-looks-like/2018/05/14/07cea4cc-57b3-11e8-8836-a4a123c359ab_story.html?noredirect=on&utm_term=.e7705ad7aab2 (last accessed May 15, 2018).

¹¹⁴ *Id.*

price increases.¹¹⁵ As the National Conference of State Legislatures has noted, “the average increase before subsidies was a shocking 25 percent.”¹¹⁶ These increases have improved profitability for insurance companies, increasing the monthly gross margins per member.¹¹⁷ As a result, the individual marketplace may be stabilizing and premiums in some areas may decrease.¹¹⁸

This, of course, leaves aside the fact that deductibles of the individual exchange plans continue to rise while the networks of coverage continue to narrow.¹¹⁹ In 2018, the average deductible for an ACA exchange silver plan was \$3,937, an increase from \$3,703 in 2017, even though bronze plan deductibles are decreasing.¹²⁰ 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.”¹²¹ 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.”¹²²

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

¹¹⁵ See *id.* (“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.”).

¹¹⁶ *Health Insurance: Premium and Increases*, NAT’L. CONF. STATE LEGISLATURES, Dec. 4, 2017, available at <http://www.ncsl.org/research/health/health-insurance-premiums.aspx> (last accessed Apr. 26, 2018).

¹¹⁷ See Cynthia Cox et al., *Individual Insurance Market Performance in Late 2017*, KAISER FAMILY FOUNDATION, Jan. 4, 2018, available at <http://www.ncsl.org/research/health/health-insurance-premiums.aspx> (last accessed Apr. 26, 2018) (“On average, premiums per enrollee grew 17 percent from third quarter 2016 to third quarter 2017, while per person claims grew only four percent”).

¹¹⁸ *Id.* (“Third quarter premium and claims data from 2017 support the notion that 2017 premium increases were necessary as a one-time market correction to adjust for a sicker-than-expected risk pool.”). See Kristi L. Nelson, *Obamacare: Lower ACA Premiums, More Options Likely for Tennesseans in 2019*, KNOXVILLE NEWS-SENTINEL, Jul. 12, 2018, available at <https://www.knoxnews.com/story/news/health/2018/07/12/obamacare-tennessee-lower-premiums-aca-2019/779414002/> (last accessed Jul. 17, 2018) (noting a reduction in premiums for 2019 individual exchange proposals).

¹¹⁹ See Dan Mangan, *Obamacare Plans Get More Restrictive and Deductibles Get Pricier in 2018*, CNBC, Nov. 30, 2017, available at <https://www.cnbc.com/2017/11/30/obamacare-plans-get-narrower-and-deductibles-get-pricier-in-2018.html> (last accessed Apr. 26, 2018).

¹²⁰ *Id.*

¹²¹ Newkirk II, *supra* note 52.

¹²² *Id.*

by 2016.¹²³ The average worker was responsible for \$3,354 in premium costs in 2008, and in 2016, the average worker was responsible for premium amounts at \$5,277.¹²⁴ More than half (51 percent) of survey respondents reported that their health insurance deductibles exceeded \$1000.¹²⁵ Relatedly, 83 percent of those employed reported that their single coverage carries a deductible, and its average amount is \$1,478.¹²⁶ In 2015, the average deductible for the same type of insurance was \$159 less, and in 2011, it was \$486 less.¹²⁷

Nonetheless, the 2016 data can paint a brighter picture. Survey results from 2016 indicated that between 2011 and 2016, health care insurance family premiums rose 20 percent, which “reflect[ed] a significant slowdown,” as premiums rose 31 percent from 2006 to 2011, and 63 percent from 2001 to 2006.¹²⁸ Further, according to President Obama’s White House, increases in premiums are much lower than they would have been without the passage and implementation of the ACA.¹²⁹ 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.”¹³⁰ Finally, it has

¹²³ See Tuttle, *supra* note 98. See also *Average Annual Workplace Family Health Premiums Rise Modest 3 Percent to \$18,142 in 2016; More Workers Enroll in High-Deductible Plans with Savings Option over Past Two Years*, KAISER FAMILY FOUNDATION, Sept. 14, 2016, available at <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/> (last accessed Apr. 18, 2018).

¹²⁴ See Tuttle, *supra* note 98.

¹²⁵ See *Average Annual Workplace Family Health Premiums Rise Modest 3 Percent to \$18,142 in 2016*, *supra* note 123.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ See Jason Furman and Matt Fiedler, *New Data Show that Premium Growth in Employer Coverage Remained Low in 2016*, White House Blog, Sept. 14, 2016, available at <https://obamawhitehouse.archives.gov/blog/2016/09/14/new-data-show-premium-growth-employer-coverage-remained-low-2016> (last accessed Apr. 17, 2018), 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.

¹³⁰ *Id.*

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.”¹³¹

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.”¹³² Nonetheless, “little evidence” has been found to support the idea “that ACA cost containment provisions produced changes necessary to ‘bend the cost curve.’”¹³³ 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,¹³⁴ and (2) the crush of additional insurance coverage in 2014 resulted in a substantial number of new beneficiaries.¹³⁵ Both trends obscure a cleaner causal story regarding the ACA’s ability to contain the cost of American health care.

II. STRUCTURAL ACCESS AND SUSTAINABLE ACCESS

In short, the ACA was focused on securing increased opportunities for individuals to *access* health *insurance*; it was not primarily focused on making health *care* *affordable*, and thus guaranteeing *secure access*. Without *affordability*, securing *access* to insurance may—for more and more Americans—seem like a pyrrhic victory. Stories categorizing the ACA as a burden continue to be spotlighted.

In February 2018, the NEW YORK TIMES spotlighted Gwen Hurd, a 30-year-old woman from New Hampshire who, after being notified that the health insurance coverage premium for her family would increase by about 60 percent to \$1200 per month, shopped for a family plan on the ACA exchange.¹³⁶ After searching on the exchange for a plan to cover their young family, Hurd and her husband found a plan with a monthly premium of \$928 and a \$6000 deductible.¹³⁷ Because her household exceeded the premium assistance tax credit cut-off (which, for a family of three, amounted to \$82,000 per year),¹³⁸ the

¹³¹ *Id.* (emphasis in original).

¹³² Janet Weiner, et al., *Effects of the ACA on Health Care Cost Containment*, Issue Brief, UNIV. OF PENNSYLVANIA LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS, Mar. 2, 2017, available at <https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment> (last accessed Apr. 18, 2018).

¹³³ Janet Weiner, et al., *Effects of the ACA on Health Care Cost Containment*, Issue Brief, UNIV. OF PENNSYLVANIA LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS, Mar. 2, 2017, available at <https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment> (last accessed Apr. 18, 2018).

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ See Goodnough, *supra* note 23.

¹³⁷ *Id.*

¹³⁸ *Id.*

Hurds faced the monthly insurance premium without any premium assistance tax credit under the ACA. 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.”¹³⁹ Indeed, Hurd’s story highlights the double-edged nature of the ACA’s access gains: people are now able to access health insurance plans that are higher quality, but, for a not insubstantial population of Americans, the care that those plans purport to provide continues to be prohibitively expensive.¹⁴⁰ It also spotlights a policy problem that is indicative of a larger philosophical shortcoming of the law: the lack of affordable health care will impact the long-term sustainability of the law.

For sure, most Americans who receive health care on the ACA individual exchanges—this year, an enrollment that approached 12 million Americans¹⁴¹—receive tax subsidies to defray the costs of health insurance.¹⁴² In the last couple of years, between 83 and 85 percent 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 increases—technocratic analgesics unavailable to Ms. Hurd and her family, which, unsurprisingly perhaps, have a tendency to breed resentment.¹⁴³

Notwithstanding the Trump administration’s decision to end the cost-sharing reduction (CSR) payments,¹⁴⁴ the premium assistance tax credit subsidies do defray the cost of monthly insurance premiums for beneficiaries. In fact, in 2015, for those registering on healthcare.gov, “tax credits averaged \$263 a month and reduced the premium by 72

¹³⁹ *Id.* Nonetheless, the plan carried a \$3,000 individual deductible and a \$6,000 deductible for her family. *Id.*

¹⁴⁰ See Terry Savage, *What to Do If You Can’t Afford Obamacare*, CHICAGO TRIBUNE, Nov. 13, 2017, available at <http://www.chicagotribune.com/business/sns-201711132014--tms--savagectnts-a20171113-20171113-column.html> (last accessed May 21, 2018); Kimberly Leonard, *Millions Excluded from Obamacare Aid, Pass on Coverage*, U.S. NEWS AND WORLD REPORT, Feb. 15, 2017, available at <https://www.usnews.com/news/health-care-news/articles/2017-02-15/priced-out-of-obamacare-some-americans-forgo-coverage> (last accessed May 21, 2018).

¹⁴¹ See Abby Goodnough, *The Final Obamacare Tally Is In. About 400,000 Fewer People Signed Up This Year.*, N.Y. TIMES, Apr. 3, 2018, available at <https://www.nytimes.com/2018/04/03/health/obamacare-enrollment-insurance-trump.html> (last accessed Apr. 25, 2018).

¹⁴² 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, available at <https://www.nytimes.com/interactive/2017/03/09/us/politics/who-is-really-affected-by-rising-obamacare-premiums.html> (last accessed Apr. 25, 2018).

¹⁴³ See *id.*; Dan Mangan, *Obamacare’s Crushing Cost to Some Families: 49 Percent Price Hike Since 2014, Premiums of \$14,300*, CNBC, May 11, 2017, available at <https://www.cnbc.com/2017/05/11/these-folks-dont-get-obamacare-subsidies-now-and-it-is-really-costing-them.html> (last accessed May 18, 2018) (

¹⁴⁴ See Pear, et al., *supra* note 41.

percent, on average.”¹⁴⁵ 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 is (mostly) working.¹⁴⁶

In this way, Hurd’s story represents a small, but not insignificant, percentage of the overall population. According to one estimate, these individuals number about 7.5 million people—an estimate that includes about 5.4 million Americans who, in 2017, purchased health insurance outside of the ACA exchanges.¹⁴⁷ These include self-employed individuals, small employers, and early retirees.¹⁴⁸ Other stories—of individuals in their late fifties paying \$1,600 per month in health care premiums and facing deductibles of \$7,500 each—have been chronicled, leading disaffected citizens to “try[] to figure out how to make less than \$64,000 so [they] can get subsidies.”¹⁴⁹

For the vast majority of Americans receiving premium assistance tax credits on the individual marketplace (mirroring the Hurds, “25,000 New Hampshire residents paid full freight for Obamacare plans” in 2017¹⁵⁰), just like the vast majority of employers receiving a tax credit for offering insurance to their workers, most Americans do not feel the full pain of increasing premiums.¹⁵¹ Nonetheless, it is true that the premium assistance tax subsidies in the ACA are graduated—so, the higher one’s income, the higher the percentage of the premium for which the individual is responsible.¹⁵²

¹⁴⁵ Robert Pear, *86 Percent of Health Law Enrollees Receive Subsidies, White House Says*, N.Y. TIMES, Mar. 10, 2015, available at <https://www.nytimes.com/2015/03/11/us/11-7-million-americans-have-insurance-under-health-act.html> (last accessed Apr. 28, 2018).

¹⁴⁶ See Newkirk II, *supra* note 52 (noting that some of the ACA’s implemented policies “have been able to do some shielding”).

¹⁴⁷ See Julie Rovner, *Steep Premiums Challenge People Who Buy Health Insurance Without Subsidies*, NPR, Oct. 7, 2017, available at <https://www.npr.org/sections/health-shots/2017/10/07/555957419/steep-premiums-challenge-people-who-buy-health-insurance-without-subsidies> (last accessed May 18, 2018).

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ See Goodnough, *supra* note 23.

¹⁵¹ See *The Distribution of Major Tax Expenditures in the Individual Income Tax System*, CONGRESSIONAL BUDGET OFFICE, May 2013, at 14, available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf (last accessed May 18, 2018); Joseph Antos, Room for Debate, *End the Exemption for Employer-Provided Health Care*, N.Y. TIMES, Dec. 6, 2016 (“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.”). See also Pear, *supra* note 145.

¹⁵² See *Health Insurance Marketplace Calculator*, KAISER FAMILY FOUNDATION, Nov. 3, 2017, available at <https://www.kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=dollars&income=31000&employer-coverage=0&people=1&alternate-plan-family=individual&adult->

Increasing premiums impact those without any premium-assistance tax credits the most, but do impact all market participants to some degree. The protective insulation that the ACA provides is not universal, and certainly not infinitely durable.

What Hurd's story—not a rare one, by the way¹⁵³—does is give an example of a canary in a coal mine, clearly establishing the differences between what can be called “structural access” and “sustainable access” within American health care under the ACA. Structural access—securing essential access to health insurance—is what the ACA contemplates, and, for the most part, accomplishes. Sustainable access—building a health care delivery and financing system that assures that the individuals who rely on it for their health care have durable, secure access to care—is a more daunting task. More and more, sustainable access will likely require government action beyond what was ultimately accomplished by the ACA—whether within the private market or outside of it altogether.¹⁵⁴

Structural Access. There are a number of markets featuring public involvement (and public money) in which the public actor—namely, the government—merely *helps* certain individuals access a service or good. These public programs do not change the underlying private market in any measurable way; instead, they simply make it *easier* for a certain set of individuals—perhaps those who otherwise would be shut out of markets due to pricing constraints—to access important goods. These public “assists” may very well be welcomed by the sellers in the marketplace because the state is expanding the potential consumers who can purchase the seller's goods. In some ways, indeed, these actions serve as a subsidy not just for the consumers of the goods, but also for the sellers of the goods by expanding the seller's market. Nonetheless, these public subsidies do not concern themselves with ensuring that those citizens reliant on the subsidies actually are able to secure the ultimate societal good.

Sustainable Access. Sustainable access requires a higher level of state involvement in a private market. It not only seeks to present the *opportunity* to access a market to a certain societal group (or all people), but it concerns itself with the added concern of *actual ability*

count=1&adults%5B0%5D%5Bage%5D=21&adults%5B0%5D%5Btobacco%5D=0&child-count=0 (last accessed Apr. 25, 2018).

¹⁵³ See Mangan, *supra* note 143 (“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.”).

¹⁵⁴ See, e.g., Clare Foran, *Bernie Sanders Makes His Pitch for Single Payer*, THE ATLANTIC, Sept. 13, 2017, available at <https://www.theatlantic.com/politics/archive/2017/09/bernie-sanders-single-payer-health-care-legislation/539676/> (last accessed May 18, 2018).

of those in the group to acquire the service or good. It is one thing, for sure, to assist citizens in their efforts to acquire the potential to access a good by subsidizing its purchase, but it is quite another to ensure that those individuals *receive* those ultimate goods for the foreseeable future.

* * * *

Leaving aside the more forceful actions a state can take to assure access of some societal good to its citizenry—including the interesting regulation of utility pricing¹⁵⁵ and the emergency doctrine of anti-gouging regulation¹⁵⁶—two analogs for the access to health care can provide illuminating details. With these societal goods, the state has intervened at various levels to ensure that its citizenry—particularly those low-income citizens—is having both nutritional and housing needs met. While millions of Americans struggle to afford these basic necessities,¹⁵⁷ like the fragmented world of health care, both of these markets remain largely private in nature, with varying state involvement through public programs. Affluent citizens are able to avoid the appearance of state assistance, taking advantage of submerged intervention.¹⁵⁸

Although complicated, these examples can provide compelling narratives about state intervention to tell the story of structural access and sustainable access. One discernable difference between other social goods and health care: in the context of providing other social goods, including the two covered below, the government has worked to provide access for those who cannot afford them. Through the ACA, the program sought to provide access to health *insurance*—which may allow one to access the ultimate good of health *care*, but does not guarantee sustainable access to the good of health care itself.

A. Food

¹⁵⁵ See Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, GEO. L.J. 101, 519 (2013).

¹⁵⁶ See Jeremy A. Greene and William V. Padula, *Targeting Unconscionable Prescription-Drug Prices—Maryland's Anti-Price-Gouging Law*, NEW. ENG. J.M. CATALYST, Oct. 2, 2017, available at <https://catalyst.nejm.org/marylands-anti-price-gouging-law/> (last accessed Jun. 26, 2018) (“It is too soon to tell what the local and national effects of the Maryland law will be. But this effort is part of a growing movement among states to address untenable increases in prescription-drug prices.”).

¹⁵⁷ “Nearly 51 million households don't earn enough to afford a monthly budget that includes housing, food, child care, health care, transportation and a cell phone.... That's 43 percent of households in the United States.” See Tami Luhby, *Almost Half of US Families Can't Afford Basics Like Rent and Food*, CNN, May 17, 2018, available at <http://money.cnn.com/2018/05/17/news/economy/us-middle-class-basics-study/index.html> (last accessed May 18, 2018).

¹⁵⁸ SUZANNE METTLER, *THE SUBMERGED STATE* (University of Chicago Press, 2011).

The most obvious example of a structural intervention of federal food subsidies is SNAP, or the Supplemental Nutrition Assistance Program.¹⁵⁹ The program “is a means-tested federal program designed to enhance the ability of low-income households to buy nutritionally adequate food.”¹⁶⁰ The program works by awarding a monthly benefit to those who qualify that “can be used legally only to purchase food.”¹⁶¹ The benefits are deposited into an identified account, allowing the beneficiaries to rely on a debit card to purchase food at approved grocery stores.¹⁶² Millions of Americans participate in the program—as of 2016, nearly 43 million Americans were enrolled,¹⁶³ which is down from a high of more than 47 million participants in 2013.¹⁶⁴ Only about 75 percent of those eligible participate.¹⁶⁵ Nearly half of SNAP recipients are children, and the average monthly individual benefit is about \$126.¹⁶⁶ As of 2013, nearly one-in-five households in Oregon, Mississippi, and Maine were SNAP recipients.¹⁶⁷

Nearly 43 million Americans on the SNAP program have *structural* access to food—that is, they are benefitted by a state “assist” to access affordable and nutritious food—but millions of Americans do not have *sustainable access* to healthy nutritious foods because they struggle to access fresh grocers. Indeed, according to 2011 numbers, about 23.5 million Americans live in food deserts.¹⁶⁸ And, if one cannot make it to the grocery store that sells the products that are

¹⁵⁹ See *Supplemental Nutrition Assistance Program (SNAP)*, U.S. DEP’T. OF AGRICULTURE, Apr. 25, 2018, available at <https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap> (last accessed May 19, 2018).

¹⁶⁰ Rosa L. Delauro, *Why America Should Save SNAP*, 52 HARV. J. ON LEGIS. 267, 268 (2015).

¹⁶¹ Amy L. Dorsch, *Food Stamps in America: How an Octogenarian Program Can Still meet the Country’s Needs*, 52 LOUISVILLE L. REV. 199 (2013).

¹⁶² See *Supplemental Nutrition Assistance Program (SNAP)*, U.S. DEP’T. OF AGRICULTURE, Sept. 13, 2017, available at <https://www.fns.usda.gov/snap/facts-about-snap> (last accessed May 18, 2018).

¹⁶³ See Max Kutner, *The Number of People on Food Stamps Is Falling. Here’s Why*, NEWSWEEK, Jul. 22, 2017, available at <http://www.newsweek.com/people-food-stamps-snap-decline-participation-640500> (last accessed May 18, 2018).

¹⁶⁴ See *Who Is on Food Stamps, by State*, GOVERNING, available at <http://www.governing.com/gov-data/food-stamp-snap-benefits-enrollment-participation-totals-map.html> (last accessed May 18, 2018).

¹⁶⁵ See *SNAP: Frequently Asked Questions*, SNAP TO HEALTH!, 2018, available at <https://www.snapttohealth.org/snap/snap-frequently-asked-questions/> (last accessed May 18, 2018).

¹⁶⁶ *Id.*

¹⁶⁷ See *Who Is on Food Stamps, By State*, *supra* note 164.

¹⁶⁸ *America’s ‘Food Deserts,’* THE WEEK, Aug. 12, 2011, available at <http://theweek.com/articles/482588/americas-food-deserts> (last accessed May 18, 2018).

covered by SNAP, the value of the state “assist” quite hollowly evaporates.

Researchers know that “there is significant overlap between urban areas where a large percentage of the population relies on food stamps and urban area with grocery stores that rarely carry fresh and nutritious food.”¹⁶⁹ Defined as “any census district where at least 20 percent of the inhabitants are below the poverty line and 33 percent live over a mile from the nearest supermarket (or in rural areas, more than ten miles),” food deserts are found in “rural swaths of West Virginia, Ohio, and Kentucky, as well as urban areas like Detroit, Chicago, and New York City.”¹⁷⁰ Complicated by newer findings that “even when families have access to healthier foods, they don’t necessarily buy them,”¹⁷¹ or that access to fresh food does not automatically change citizens’ diets,¹⁷² the problem of America’s food deserts is subject to divergent policy prescriptions.

The Trump administration has proposed drastically changing the SNAP program, replacing it with a widely-panned program that would focus on the delivery of “Harvest Boxes.”¹⁷³ The administration “has likened [the proposed plan] to Blue Apron, a high-end meal kit service.”¹⁷⁴ No matter the feasibility of the program—it has been criticized due implementation-based concerns, bringing about a loss of autonomy of recipients, and harming grocers¹⁷⁵—the Trump administration proposal would actually move the program from the structural access-based SNAP program to a sustainable access-based home delivery plan.

Indeed, different from the health care market, one who lacks access to fresh groceries but receives SNAP can still access food—

¹⁶⁹ Rebecca Lee, *Quenching Food Deserts: Rethinking Welfare Benefits to Combat Obesity*, 25 S. CAL. REV. L. & SOC. JUST. 241, 248 (2016).

¹⁷⁰ *America’s ‘Food Deserts,’* THE WEEK, Aug. 12, 2011, available at <http://theweek.com/articles/482588/americas-food-deserts> (last accessed May 18, 2018).

¹⁷¹ Vanessa Sumo, *The Conventional Wisdom on Food Deserts May Be All Wrong*, CHICAGO BOOTH REVIEW, Jan. 3, 2018, available at <http://review.chicagobooth.edu/marketing/2018/article/conventional-wisdom-food-deserts-may-be-all-wrong> (last accessed May 18, 2018).

¹⁷² See Sarah Corapi, *Why It Takes More Than a Grocery Store to Eliminate a ‘Food Desert,’* PBS NEWSHOUR, Feb. 3, 2014, available at <https://www.pbs.org/newshour/health/takes-grocery-store-eliminate-food-desert> (last accessed May 18, 2018).

¹⁷³ See Craig Gundersen, Opinion, *SNAP is Successful Because It Treats Recipients With Dignity and Autonomy*, THE HILL, Mar. 16, 2018, available at <http://thehill.com/opinion/healthcare/378630-snap-is-successful-because-it-treats-recipients-with-dignity-and-autonomy> (last accessed May 18, 2018).

¹⁷⁴ Natasha Bach, *Trump Wants to Cut Food Stamps—And Replace Them With Blue Apron-Like Food Boxes*, FORTUNE, Feb. 13, 2018, available at <http://fortune.com/2018/02/13/food-stamps-blue-apron-americas-harvest-box/> (last accessed May 19, 2018).

¹⁷⁵ *Id.*

perhaps low-quality food from a convenience store, but sustenance nonetheless. One who receives tax subsidies to purchase health insurance but who cannot afford the high deductible cannot afford health *care*, impacting access. There's no low-quality alternative. This, of course, is heightened in cases where individuals are impacted by some highly-expensive and life-threatening condition like cancer.¹⁷⁶

And there may be other reasons why the state would want to choose structural access over sustainable access when it comes to food policy. Perhaps policymakers understand that, beyond preventing hunger, the state has an interest in also protecting individual dignity and autonomy of those receiving food assistance.¹⁷⁷ In other words, there is surely something valuable about preventing hunger, but there is also something valuable about protecting the autonomy and dignity of those on the program.¹⁷⁸ SNAP funds are required to be used “to buy nutritious foods such as breads and cereals, fruits and vegetables, meat and fish and dairy products,”¹⁷⁹ but also allow its recipients to purchase sugary soft drinks and junk food—a target of a number of health and governance groups.¹⁸⁰

Tracking this position, the U.S.D.A. has reported that SNAP funds are being spent on junk food, but also that banning the purchase of unhealthy foods for the SNAP population is unfair.¹⁸¹ In order to respect these additional interests, but also provide a more sustainable solution, then, perhaps a subsidy for the construction of new grocery stores,¹⁸² or subsidies for public transit trips for those to travel to the

¹⁷⁶ 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).

¹⁷⁷ See Jacqueline Alemany, *From a SNAP Recipient to Trump: Food Box Is a “Terrible Idea,”* CBS NEWS, Feb. 16, 2018, available at <https://www.cbsnews.com/news/from-a-snap-recipient-to-trump-food-box-is-a-terrible-idea/> (last accessed May 18, 2018).

¹⁷⁸ *Id.*

¹⁷⁹ *Understanding SNAP, the Supplemental Nutrition Assistance Program, Formerly Food Stamps*, FEEDING AMERICA, available at <http://www.feedingamerica.org/take-action/advocate/federal-hunger-relief-programs/supplemental-nutrition-assistance-program.html> (last accessed May 18, 2018).

¹⁸⁰ See Anahad O'Connor, *In The Shopping Cart of a Food Stamp Household: Lots of Soda*, N.Y. TIMES, Jan. 13, 2017, available at <https://www.nytimes.com/2017/01/13/well/eat/food-stamp-snap-soda.html> (last accessed May 18, 2018).

¹⁸¹ *Id.*

¹⁸² The Pennsylvania Fresh Food Financing Initiative “funded 88 projects for fresh food retail, created or preserved 5,000 jobs and 400,000 Pennsylvanians gained improved access to healthy food.” *Pennsylvania Model Fresh Food Financing Initiative Celebrates Success; Discusses Work to Be Done*, PENNSYLVANIA FOOD MERCHANTS ASS'N., Dec. 18, 2015, available at <http://www.pfma.org/news-archive/-pennsylvania-model-fresh-food-financing-initiative-celebrates-success-discusses-work-to-be-done> (last accessed May 18, 2018).

nearest grocery store,¹⁸³ would be better options. In the meantime, given the cross-currents, structural access-based policies have served as the current solution.

B. Housing

Created by the Housing and Community Development Act of 1974,¹⁸⁴ the most obvious structural access intervention for housing is the federal Section 8 voucher program.¹⁸⁵ For apartments that are eligible for Section 8 vouchers, the recipient pays up to 30 percent of her income, and the voucher covers the rest.¹⁸⁶ The landlord is required to meet programmatic regulatory requirements.¹⁸⁷ Today, about 2.2 million families receive a subsidy under the Housing Choice Voucher program.¹⁸⁸

Nonetheless, under the Trump administration, the program may change. An administration proposal seeks to “redefine housing assistance,”¹⁸⁹ which would raise the “minimum monthly rents in

¹⁸³ ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD: MEASURING AND UNDERSTANDING FOOD DESERTS AND THEIR CONSEQUENCES, Economic Research Service (June 2009), at 5, available at https://www.ers.usda.gov/webdocs/publications/42711/12716_ap036_1_.pdf (last accessed May 18, 2018) (“For example, if those people who have low incomes and limited access are scattered throughout areas with lower concentrations of poor people, then opening up a new supermarket may be less effective than policies that make individual or group transportation to stores less expensive (for example, bus/transit subsidies, store shuttle services, or improved bus routes”).

¹⁸⁴ See Shelby D. Green, *The Public Housing Tenancy: Variations on the Common Law That Give Security of Tenure and Control*, 43 CATH. U. L. REV. 681, 695 (1994).

¹⁸⁵ See Housing Choice Vouchers Fact Sheet, U.S. DEP’T. HOUSING AND URBAN DEVELOPMENT, available at https://www.hud.gov/topics/housing_choice_voucher_program_section_8 (last accessed Apr. 26, 2018).

¹⁸⁶ See Charles V. Bagli, *Sale of Brooklyn Housing Complex Would Benefit Trump*, N.Y. TIMES, Sept. 6, 2017, available at <https://www.nytimes.com/2017/09/06/nyregion/starrett-city-housing-complex-trump-sale.html> (last accessed May 18, 2018).

¹⁸⁷ See Housing Choice Vouchers Fact Sheet, U.S. DEP’T. OF HOUSING AND URBAN DEVELOPMENT, available at https://www.hud.gov/topics/housing_choice_voucher_program_section_8 (last accessed May 18, 2018) (“The role of the landlord ... is to provide decent, safe, and sanitary housing to a tenant at a reasonable rent. The dwelling unit must pass the program’s housing quality standards and be maintained up to those standards as long as the owner receives housing assistance.”).

¹⁸⁸ See Alana Semuels, *How Housing Policy Is Failing America’s Poor*, THE ATLANTIC, Jun. 24, 2015, available at <https://www.theatlantic.com/business/archive/2015/06/section-8-is-failing/396650/> (last accessed May 18, 2018).

¹⁸⁹ Glenn Thrush, *HUD Floats a Plan Intended to Reduce Reliance on Housing Assistance*, N.Y. TIMES, Apr. 25, 2018, available at

public housing developments and for the recipients of Section 8 vouchers rising to \$150 a month from \$50.”¹⁹⁰ Further, the proposal would increase the “rent for tenants in subsidized housing to 35 percent of gross income ..., up from the current standard of 30 percent of adjusted income.”¹⁹¹ Finally, according to reporting on the proposal, it “would also increase rents for elderly and disabled people after six years” and would give local governments the ability “to impose work requirements on tenants in public housing deemed fit for work.”¹⁹²

Whether or not the program’s parameters shift, what is clear is that the Section 8 program is designed to secure only structural access. While the federal government elects to pay for the majority of the rents of low-income qualified individuals, there still remains a shortage of individuals who are actually able to secure affordable housing.¹⁹³ Further, the 2.2 million families receiving a housing subsidy are reportedly “only about 25 percent of eligible households.”¹⁹⁴ An indisputable “affordable housing gap” exists in the United States.¹⁹⁵ But notwithstanding whether or not landlords rent to individuals who receive vouchers, the program is characteristically a structural access policy because the federal government “foots a portion” of rent for low-income individuals who need housing. It provides an “assist” to those who need it, pushing them onto the private market with a voucher. Like SNAP, it is responsible for a percentage of the bill.

But this structural access solution to housing is incomplete. Indeed, if the underlying market is *too expensive* or *too competitive*, then the voucher does not adequately insulate individual citizens from its worst effects; for sure, a program like Section 8 does not worry with

<https://www.nytimes.com/2018/04/25/us/hud-housing-assistance.html> (last accessed Apr. 26, 2018).

¹⁹⁰ *Id.*

¹⁹¹ See Tracy Jan et al., *HUD Secretary Ben Carson to Propose Raising Rent for Low-Income Americans Receiving Federal Housing Subsidies*, WASH. POST, Apr. 25, 2018, available at <https://www.washingtonpost.com/news/wonk/wp/2018/04/25/hud-secretary-ben-carson-to-propose-raising-rent-for-low-income-americans-receiving-federal-housing-subsidies/> (last accessed Jun. 27, 2018).

¹⁹² Thrush, *supra* note 189.

¹⁹³ See Semuels, *supra* note 188 (“One study in Austin found that there were plenty of apartments around the city that voucher-holders could afford. But only a small portion of those apartments would rent to voucher-holders.”). Further, cities and states have passed laws that seek to prevent “landlords from refusing to rent to people solely because they have a voucher.” *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ See Sarah Holder, *For Low-Income Renters, the Affordable Housing Gap Persists*, CITYLAB, Mar. 13, 2018, available at <https://www.citylab.com/equity/2018/03/for-low-income-renters-the-gap-in-affordable-housing-persists/555458/> (last accessed May 19, 2018) (“for every 100 households categorized as extremely low income (ELI), only 35 affordable rental homes are available—a shortage of over seven million affordable and available homes”).

whether individuals are actually able to achieve and secure affordable housing—which may explain its undersubscription. It may also explain cities’ embrace of rent control ordinances and the federal public housing program, programs that operate to ensure individuals can continue secure apartments amid skyrocketing rents.¹⁹⁶

But there are sustainable access examples in housing policy. Similar to legislation in the health care space for rate regulation for hospitals in Maryland,¹⁹⁷ the tool of rent control—a sustainable access policy solution—imposes a governmental cap on the amount the landlord can charge in rent. While rent control efforts in New York City, which have their roots in the 1940s, have been eclipsed by the city’s “rent stabilization” efforts,¹⁹⁸ rent control nonetheless “limits the rent an owner may charge for an apartment and restricts the right of any owner to evict tenants.”¹⁹⁹ In New York City’s rent control regime, a landlord cannot exceed the maximum base rent (MBR), which is “established for each apartment.”²⁰⁰ Alternatively, rent stabilization empowers “a city board of experts annually” to “determine[] how much more landlords can charge their tenants.”²⁰¹ This focuses on the “rates for rent increases in stabilized apartments.”²⁰² Rent stabilization, which is part of New York City’s “rent regulation programs,” limits rent increases, and provides additional protection for tenants.²⁰³ A 2014

¹⁹⁶ See, e.g., Zac Self, *National City Group Fights to Get Rent Control Ordinance on November Ballot*, KGTV SAN DIEGO, MAY 17, 2018, available at <https://www.10news.com/news/making-it-in-san-diego/national-city-group-fights-to-get-rent-control-ordinance-on-november-ballot> (last accessed May 18, 2018).

¹⁹⁷ See Theodore R. Marmor and Michael S. Barr, *Making Sense of the National Health Insurance Reform Debate*, 10 YALE L. & POL’Y REV. 228, 275 (1992) (“Maryland has administered a relatively cost-effective system of hospital rate regulation since 1974, lowering its hospital costs as a result.”); Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 129 (2015) (“The best-known example of rate regulation is Maryland’s all-payer rate setting model, but other models include a version of rate-setting that allows some price variation between hospitals, caps on rates negotiated by private payers, or global budgets.”).

¹⁹⁸ See Adam Davidson, *The Perverse Effects of Rent Regulation*, N.Y. TIMES, Jul. 23, 2013, available at <https://www.nytimes.com/2013/07/28/magazine/the-perverse-effects-of-rent-regulation.html> (last accessed Apr. 25, 2018).

¹⁹⁹ See *#1 Rent Stabilization and Rent Control*, NEW YORK DIVISION OF HOUSING AND COMMUNITY RENEWAL OFFICE OF RENT ADMINISTRATION, Dec. 2017, at 3, available at <http://www.nyshcr.org/Rent/FactSheets/orafac1.pdf> (last accessed Apr. 25, 2018).

²⁰⁰ *Id.* at 3.

²⁰¹ Davidson, *supra* note 198.

²⁰² *#1 Rent Stabilization and Rent Control*, *supra* note 199.

²⁰³ *Id.* (“Rent stabilization provides protections to tenants besides limitations on the amount of rent. Tenants are entitled to receive required services, to have their leases renewed, and may not be evicted except on grounds allowed by law.”).

survey found that 27,000 rent controlled apartments are in New York City, compared with over one million rent stabilized apartments.²⁰⁴

Interestingly, new rent control regimes have made recent headlines in other large American cities. Los Angeles Mayor Eric Garcetti commented that “he would ‘absolutely’ consider extending rent restrictions in Los Angeles to cover newly built apartments if California voters repeal a state law that prohibits it.”²⁰⁵ Los Angeles’s rent stabilization rules “limit how much landlords can increase rent annually on tenants living in apartments built before October 1978,” and California’s Cost-Hawkins Rental Housing Act “ban[ned] cities and counties from capping rent increases on apartments built after 1995.”²⁰⁶ Just this past March, Chicagoans were asked to vote on whether they would support the repeal of a 1997 state law that prohibits rent control laws in the state.²⁰⁷ Amidst low turnout, voters overwhelmingly supported the non-binding “advisory referendum.”²⁰⁸ Although no laws have changed, in 2017, a bill was introduced in the state legislature that would repeal the state ban, and Illinois gubernatorial candidates have voiced public support for its repeal.²⁰⁹

C. Health Care

Unapologetically, the ACA’s goals are threefold—they are to regulate private insurance, expand Medicaid, and to influence medical decision-making.²¹⁰ True, the ACA’s “central focus ... is expanding coverage and strengthening consumer protections in the health insurance marketplace through government regulation.”²¹¹ Thus, the

²⁰⁴ *Rent Control FAQ*, NYC RENT GUIDELINES BOARD, available at <https://www1.nyc.gov/site/rentguidelinesboard/resources/rent-control.page> (last accessed Apr. 25, 2018).

²⁰⁵ Emily Alpert Reyes and David Zahniser, *Garcetti Says He Would Consider Expanding Rent Control in L.A.*, L.A. TIMES, Apr. 23, 2018, available at <http://www.latimes.com/local/lanow/la-me-ln-garcetti-costa-hawkins-20180422-story.html> (last accessed Apr. 26, 2018).

²⁰⁶ *Id.*

²⁰⁷ See Dennis Rodkin, *Rent Control? Chicago Voters Like the Idea.*, CRAIN’S CHICAGO BUSINESS, Mar. 21, 2018, available at <http://www.chicagobusiness.com/realestate/20180321/CRED0701/180329964/rent-control-chicago-voters-like-the-idea> (last accessed Apr. 25, 2018).

²⁰⁸ *Id.*

²⁰⁹ See Darcel Rockett, *Could, and Should, Illinois Embrace Rent Control?*, CHICAGO TRIBUNE, Jan. 30, 2018, available at <http://www.chicagotribune.com/classified/realestate/ct-re-rent-control-in-illinois-20180125-story.html> (last accessed Apr. 26, 2018).

²¹⁰ See J.B. Silvers, *The Affordable Care Act: Objectives and Likely Results in an Imperfect World*, 11 ANN. FAM. MED. 402 (Sept. 2013), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767707/> (last accessed May 18, 2018).

²¹¹ Drew Altman, *The Fundamentally Different Goals of the Affordable Care Act and Republican Replacement Plans*, KAISER FAMILY FOUNDATION, Jun. 7, 2016,

chief regulatory thrust was directed at reforming (and, in fact, reconstructing) a private market. And, again, it has reinvented American health insurance in this country.

But making a market more protective of consumers not only includes guaranteeing their rights to hypothetically access that market—from which many of whom had been excluded—but it also demands that that market is sustainable. For various reasons covered in the next section, the American health care market is subject to uniquely debilitating pressures that severely strain its functionality. Consumer protection without cost control mechanisms in the health care marketplace lacks the hallmarks of consumer protection; the Hurds of New Hampshire surely do not feel as though the ACA is a consumer protection statute.²¹² As a result, the ACA does not achieve sustainable access to health care. Individuals missing from the health insurance marketplace for decades now have an opportunity to acquire health *insurance*, but they are not guaranteed health *care*.²¹³ In fact, even those who have purchased ACA exchange plans have still struggled to achieve access to health care.²¹⁴

Chief Justice John Roberts, in the seminal case of *NFIB v. Sebelius*—which gummed the gears of the ACA’s universality goals—highlighted the distinction between health insurance and health care:

available at <https://www.kff.org/health-reform/perspective/the-fundamentally-different-goals-of-the-affordable-care-act-and-republican-replacement-plans/> (last accessed May 18, 2018).

²¹² See Discussion and accompanying notes, *supra* notes 136-39.

²¹³ All Americans are presumably guaranteed a right to health care in the emergency room under EMTALA. See discussion and accompanying notes, nn. 15, 24. Even universal access to emergency services still appears to be politically contentious. See Holly Fletcher, *Diane Black Wants ERs to Be Able to Send People Away. Here Are the Issues for Patients, Doctors.*, TENNESSEAN, Oct. 20, 2017, available at <https://www.tennessean.com/story/money/industries/health-care/2017/10/20/diane-black-wants-ers-able-send-people-away-here-issues-patients-doctors/779598001/> (last accessed May 21, 2018) (“Black, a Republican gubernatorial candidate and former nurse, said a federal law, called EMTALA is a ‘burden’ that took away clinicians’ ability to tell patients that ‘an emergency room is not the proper place’ for treatment.... ‘I would get rid of a law that says that you—you are not allowed, as a health care professional, to make that decision about whether someone can be appropriately treated the next day, or at a walk-in clinic, or at their doctor.’”). Importantly, EMTALA does not require doctors to treat all patients who walk into their emergency rooms but requires them to perform a medical screening examination on all those who may be experiencing an emergency; in effect, it requires doctors to treat all patients who walk in to the ER while experiencing an emergency. See *Emergency Medical Treatment & Labor Act (EMTALA)*, CENTERS FOR MEDICARE AND MEDICAID SERVS., Mar. 26, 2012, available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/> (last accessed May 21, 2018).

²¹⁴ See Elizabeth Rosenthal, *Sorry, We Don’t Take Obamacare*, N.Y. TIMES, May 14, 2016, available at <https://www.nytimes.com/2016/05/15/sunday-review/sorry-we-dont-take-obamacare.html> (last accessed May 23, 2018).

to him, they are clearly different things.²¹⁵ This distinction highlights the shortcoming of the ACA: health insurance and health care are not the same, and, in fact, “proximity and degree of connection between [them] [were] too lacking” for the court to uphold the ACA under the Commerce Clause.²¹⁶ The establishment of the ACA—and particularly its individual mandate—does not sufficiently solve America’s health care crisis because it doesn’t provide sustainable access to *care* for millions of Americans.

In other realms mentioned above, the state has sought to achieve either structural or sustainable access following an examination of the goals of various policies and the nature of the societal challenge. In the food subsidy context, delivering nutritious food—a clear sustainable access solution—has its costs: it may, the argument goes, devalue the autonomy of individuals who receive SNAP, which is another societal value worth protecting. In the housing subsidy context, the state has provided vouchers to individuals in need of affordable housing, and, typically starting in the 1970s,²¹⁷ where those vouchers have not succeeded in achieving the goal of securing housing for low-income individuals in the nation’s largest cities—particularly San Francisco, Los Angeles, New York, and Washington, D.C.—they have established rent control programs.²¹⁸ Cities including Chicago²¹⁹ and Seattle²²⁰ have examined rent control programs, ending up with seemingly different current stances.

But, not health care. In the individual marketplace exchange, the ACA has created a system that focuses on *structural* access—helping individuals access private insurance—but, without meaningful cost control, the ACA has not built a system of *sustainable* access. Access to the health insurance market approaches worthlessness without the ability to access and pay for health care.

As an ultimate policy matter, then, choosing merely structural access in health care policy seems incomplete, considering that the structural access gains become particularly precarious without

²¹⁵ N.F.I.B. v. Sebelius, 567 U.S. 519, 558 (2012).

²¹⁶ *Id.*

²¹⁷ See Scott Beyer, *How Ironic: America’s Rent-Controlled Cities Are Its Least Affordable*, FORBES, Apr. 24, 2015, available at <https://www.forbes.com/sites/scottbeyer/2015/04/24/how-ironic-americas-rent-controlled-cities-are-its-least-affordable/#2bfa72c648c6> (last accessed May 18, 2018).

²¹⁸ See *id.*

²¹⁹ See Jacqueline Serrato, *Chicagoans Have Spoken: They Want Rent Control, Legal Weed, and Gun Restrictions*, CHICAGO TRIBUNE, Mar. 21, 2018, available at <http://www.chicagotribune.com/voiceit/ct-chicagoans-have-spoken-they-want-rent-control-legal-weed-and-gun-restrictions-20180321-story.html> (last accessed May 18, 2018).

²²⁰ See Hayat Norimine, *State Will Uphold Its Ban on Rent Control*, SEATTLE MET, Feb. 5, 2018, available at <https://www.seattlemet.com/articles/2018/2/5/state-will-uphold-its-ban-on-rent-control> (last accessed May 18, 2018).

aggressive structural reforms. But it may actually be worse than that: the failure to adequately install a system that brings about cost control, while simultaneously providing structural access focused on insulating (most of) the public from the financial harm *actually harms* the law's ability to contain price increases—and may further incentivize or sanction price increases. These price increases occur, consumers are harmed, and political support of the law continues to weaken as more and more of its beneficiaries are exposed to the sharp financial pain of the cost of American health care.

This observation should be unremarkable when one follows the rhetoric surrounding the ACA: ultimately, it is not health *insurance* that draws a deep moral and political commitment from Americans, it is health *care*. No group of Americans is clamoring for the ability to have help accessing a private insurance marketplace, but Americans are clamoring for affordable, universal health care.²²¹ What seemingly drove the ACA was not a sanitized appeal to private market fairness, but rather its moral case that health care is a universal right.²²² According to former President Obama in 2017, when speaking about efforts to repeal the ACA,

[w]e didn't fight for the Affordable Care Act for more than a year in the public square for any personal or political gain—we fought for it because we knew it would save lives, prevent financial misery, and ultimately set this country we love on a better, healthier course.... The Senate bill, unveiled today, is not a health care bill.... Simply put, if there's a chance you might get sick, get old, or start a family—this bill will do you harm. And small tweaks over the course of the next couple weeks, under the guise of making these bills

²²¹ And these arguments have seemingly only gotten louder during the effort to repeal and replace. See Lawrence Moss, *Americans Have Decided Universal Healthcare is a Basic Right*, NEWSWEEK, Aug. 22, 2017, available at <http://www.newsweek.com/americans-have-decided-universal-healthcare-basic-right-652128> (last accessed May 18, 2018); Vann R. Newkirk II, *A Political Opening for Universal Health Care?*, THE ATLANTIC, Feb. 14, 2017, available at <https://www.theatlantic.com/politics/archive/2017/02/universal-health-care-polls-obamacare-repeal/516504/> (last accessed May 18, 2018); Ricardo Alonso-Zaldivar, *62 Percent of U.S. Want Federal Government to Ensure Health Care For All*, Poll Says, PBS NEWS HOUR, Jul. 20, 2017, available at <https://www.pbs.org/newshour/health/62-percent-u-s-want-federal-government-ensure-health-care-poll-says> (last accessed May 18, 2018).

²²² See Vann R. Newkirk II, *Obama: "This Bill Will Do You Harm,"* THE ATLANTIC, Jun. 22, 2017, available at <https://www.theatlantic.com/politics/archive/2017/06/this-is-the-obamacare-speech-obama-never-gave/531330/> (last accessed May 18, 2018).

easier to stomach, cannot change the fundamental meanness at the core of this legislation.²²³

But, as mentioned above, the law does not achieve the goals of universal health care because its prescriptions are incomplete. These arguments—focused on how the fragmented structural access provided by the ACA actually weakens the attempt to actually achieve universality—are explored in depth below.

III. PUBLICIZING PRIVATE ACTORS

After an escalating threat throughout the summer of 2017,²²⁴ that the ACA survived the repeal effort, lumbering along into 2018, is nothing short of remarkable. That neither a full repeal nor the collapse of the individual marketplace occurred is surely stunning. Equally stunning was the direction of Senator John McCain’s thumb at approximately 2 a.m. EDT on Friday, July 28, 2017.²²⁵ Regarding the inner-core of the ACA—through two massive Court decisions, a coordinated repeal effort, and a bevy of regulatory sabotage—the last decade has been a story of survival by fingernail-sized margins. But as political support and policy purchase remains brittle, the ACA is locked in a permanent state of instability²²⁶—exacerbated by policy design that is reliant on a finicky private marketplace.

Indeed, the ACA has not escaped unscathed. While its core remains intact, CSR payments have ended, and the individual mandate

²²³ *Id.*

²²⁴ Nonetheless, a good portion of the focus of the American Health Care Act—and the Senate’s version—was dismembering and hollowing the Medicaid program, not necessarily on the ACA. See Vann R. Newkirk II, *The Senate Puts Medicaid on the Chopping Block*, THE ATLANTIC, Jun. 22, 2017, available at <https://www.theatlantic.com/politics/archive/2017/06/ahca-senate-draft-medicaid-changes/531231/> (last accessed Jun. 25, 2018) (“it restricts and slashes Medicaid funding deeply over the next decade”).

²²⁵ See Carl Hulse, *McCain Provides a Dramatic Finale on Health Care: Thumb Down*, N.Y. TIMES, Jul. 28, 2017, available at <https://www.nytimes.com/2017/07/28/us/john-mccains-real-return.html> (last accessed Apr. 25, 2018); Lauren Fox, *John McCain’s Maverick Moment*, CNN, Jul. 28, 2017, available at <https://www.cnn.com/2017/07/28/politics/john-mccain-maverick-health-care/index.html> (last accessed Apr. 25, 2018).

²²⁶ Most recently now, twenty states have filed a lawsuit to declare the ACA unconstitutional following the repeal of the individual mandate. See Erica Treichert, *Twenty States Sue Federal Government to Abolish Obamacare*, MODERN HEALTHCARE, Feb. 26, 2018, available at <http://www.modernhealthcare.com/article/20180226/NEWS/180229931> (last accessed May 21, 2018) (“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.”).

penalty has been repealed.²²⁷ The decision by the Trump administration to end the CSR payments will save the federal government \$10.0 billion, but will cost it an additional \$12.3 billion in increased premium-assistance tax credits in 2018.²²⁸ Elimination of the individual mandate will cost the system—and American beneficiaries within that system—more, as admitted by the former HHS Secretary Tom Price, one of the acerbic critics of the ACA,²²⁹ in a jaw-dropping statement in the spring of 2018.²³⁰

Not only did Congress’s attempts to destroy the ACA constitute an existential threat, but the uncertainty that was created by the drumbeat of repeal and replace was expected to legitimately spook private insurers from the marketplace, causing already teetering markets to collapse. Some markets seemed poised to fully collapse in 2017, but did not.²³¹ Nonetheless, not to be deterred by facts when it

²²⁷ See Pear et al., *supra* note 41; Sanger-Katz, *Requiem*, *supra* note 41.

²²⁸ See Larry Levitt et al., *The Effects of Ending the Affordable Care Act’s Cost-Sharing Reduction Payments*, KAISER FAMILY FOUNDATION, Apr. 25, 2017, available at <https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/> (last accessed May 21, 2018); Rabah Kamal et al., *How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums*, KAISER FAMILY FOUNDATION, Oct. 27, 2017, available at <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/> (last accessed May 21, 2018).

²²⁹ See Margaret Hartmann, *Trump Shows Commitment to Destroying Obamacare By Picking Tom Price for HHS*, NEW YORK MAG., Nov. 29, 2016, available at <http://nymag.com/daily/intelligencer/2016/11/trump-tom-price-obamacare-hhs.html> (last accessed May 22, 2018) (“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.’”); Audrey Carlsen and Haeyoun Park, *The Same Agency That Runs Obamacare Is Using Taxpayer Money to Undermine It*, N.Y. TIMES, Sept. 4, 2017, available at <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.”) (last accessed May 21, 2018).

²³⁰ See Eliza Collins, *Former HHS Sec. Price: Repealing the Individual Mandate “Will Harm” People Insured Through Obamacare*, USA TODAY, May 1, 2018, available at <https://www.usatoday.com/story/news/politics/onpolitics/2018/05/01/former-hhs-sec-price-repealing-individual-mandate-harm/568281002/> (last accessed May 20, 2018) (“‘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*.”).

²³¹ See Gabrielle Levy, *Last “Bare” County in U.S. to Have Obamacare Coverage in 2018*, U.S. NEWS & WORLD REPORT, Aug. 24, 2017, available at <https://www.usnews.com/news/national-news/articles/2017-08-24/last-bare-county-in-us-to-have-obamacare-coverage-in-2018> (last accessed May 21, 2018).

comes to the ACA, in a recent poll, 53 percent of Americans think the ACA marketplaces are collapsing.²³²

Inaccurate reports of its demise aside, the ACA—in order to remain politically viable—must now work harder to sufficiently insulate beneficiaries from the worst effects of rising health insurance premiums. Tracking America’s enduring dichotomous approach in this area, the ACA—by relying on the private marketplace—puts its long-term sustainability at major risk. Indeed, in order to ensure that private insurance companies participate on the insurance marketplaces, the deals must be sweet enough to assure their continued voluntary participation. But these markets are subject to design flaws.

These specific marketplace challenges include (1) an intractable incompatibility of interests, (2) insufficient regulatory “caps,” and (3) a dependence on corporate cooperation. These challenges can ultimately hamstring the effectiveness of the law, resulting in (4) socioeconomic chafing, and, finally, (5) political and regulatory degradation. Each of these phenomena are explored in-depth below.

A. Intractable Incompatibility of Interests

The federal government and America’s private insurance companies share an immiscible conflict of interests: one has sought, most prominently through the ACA, to expand access to insurance and care, whereas the other, to remain viable, has to limit access to care in some organized and scientific way. But yet, instead of trying to protect beneficiaries by directly regulating the cost of care, the ACA opted to enlist and subsidize private insurance plans. In order to spread access to health insurance, the federal government decided to protect beneficiaries on the *back end*. This structure highlights a challenge for the ACA’s organizing structure.

Health insurance, by its very nature, operates as a risk-spreading mechanism. For an insurance company to increase its profits, it has to collect more in premiums than it pays out in claims. It can accomplish this goal in one of two ways: it can either increase premiums or it can 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, particularly, not accessing *expensive* health care.

²³² See Rachel Bluth, *Americans Have Mixed Feelings About the ACA’s Future—But Like Their Plans*, KAISER HEALTH NEWS, Apr. 3, 2018, available at <https://khn.org/news/americans-have-mixed-feelings-about-the-acas-future-but-like-their-plans/> (last accessed May 18, 2018) (Further, “only 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”).

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, they cannot be: instead, 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. 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 cover. 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. Through dense new regulations, the federal government required the individual private health insurance market to undertake a grand reorganizing, one in which participating insurance companies consented to cover preventive care services, essential health benefits, and individuals with preexisting conditions, all while agreeing to abstain from medical underwriting, which had previously allowed insurance companies to “price in” the amount of risk that each beneficiary represented. To sweeten the deal, the federal government promised to heavily subsidize the new market,²³³ to protect the companies from uncertainty,²³⁴ and, most importantly, to force millions of Americans—specifically, healthy Americans—into the new market.²³⁵ What the law did not do was constrict the cost of health care.²³⁶

²³³ See *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAMILY FOUNDATION, Nov. 8, 2017, available at <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/> (last accessed Jun. 28, 2018).

²³⁴ See Cynthia Cox et al., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, KAISER FAMILY FOUNDATION, Aug. 17, 2016, available at <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/> (last accessed Jun. 28, 2018) (“The program worked by cushioning insurers participating in exchanges and marketplaces from extreme gains and losses.”).

²³⁵ *Questions and Answers on the Individual Shared Responsibility Provision*, IRS, available at <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision> (last accessed Jun. 28, 2018). 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, available at <https://www.nytimes.com/2018/01/14/us/politics/employer-mandate.html> (last accessed Jun. 28, 2018).

²³⁶ The obvious—and enduring—problem with this endeavor is the necessity of the profit motive. Insurance companies—to secure their profits—have to skillfully balance their risk (and limit sick Americans’ access). This oxygen for insurance companies is in direct conflict with the federal government’s interest in ensuring access to health access to these Americans. Indeed, there is no fixing these

B. The Insufficiency of Medical-Loss Ratio

Called “arguably one of the most effective tools the White House has to hold down premium costs,”²³⁷ and the “Obamacare provision that terrifies insurers,”²³⁸ 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.”²³⁹ 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.”²⁴⁰ Housed within the sprawling ACA,²⁴¹ the MLR was intended to “limit supposedly wasteful and self-serving spending by insurers.”²⁴² Specifically, the MLR works by limiting “the portion of premium dollars health insurers may spend on administration, marketing, and profits,”²⁴³ and mandating that “insurers must spend at least 80 percent of their premium revenue on medical care and quality improvement.”²⁴⁴ (For large group insurers, the companies must spend at least 85 percent.²⁴⁵)

The remaining 20 percent (or 15 percent) of each dollar collected via premiums can be allocated to “pay overhead expenses,

incompatible interests: for the government to “win” by providing access *and* holding down costs, the insurance company has to “lose,” and vice versa. Given the importance of the insurance companies’ participation in the marketplace, the federal government adopts a policy stance that protects insurance companies’ profit, surely at the exclusion of any cost control.

²³⁷ Sarah Kliff, *The Obamacare Provision that Terrifies Insurers* WASH. POST WONKBLOG, Jul. 18, 2013, available at https://www.washingtonpost.com/news/wonk/wp/2013/07/18/the-obamacare-provision-that-terrifies-insurers/?utm_term=.c3052c24840b (last accessed May 4, 2018).

²³⁸ *Id.*

²³⁹ David Hudson, *The “80/20 Rule” Is Saving Americans a Lot of Money. But What Exactly Is It?*, WHITE HOUSE BLOG, Jul. 24, 2014, available at <https://obamawhitehouse.archives.gov/blog/2014/07/24/8020-rule-saving-americans-lot-money-what-exactly-it> (last accessed May 5, 2018).

²⁴⁰ Rick Ungar, *The Bomb Buried In Obamacare Explodes Today—Hallelujah!*, FORBES, Dec. 2, 2011, available at <https://www.forbes.com/sites/rickungar/2011/12/02/the-bomb-buried-in-obamacare-explodes-today-halleluja/#ccf9c0a4fab6> (last accessed May 22, 2018).

²⁴¹ See 42 U.S.C.A. 300gg-18 (2010); 45 C.F.R. 158.210 (2011) (“Minimum Medical Loss Ratio”).

²⁴² Sally Pipes, Contributor, *HHS Can Target Obamacare’s Medical Loss Ratio Rule Right Away*, FORBES, Apr. 17, 2017, available at <https://www.forbes.com/sites/sallypipes/2017/04/17/hhs-can-target-obamacares-medical-loss-ratio-rule-right-away/#b7a850973220> (last accessed May 5, 2018).

²⁴³ *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, *supra* note 89.

²⁴⁴ Julie Appleby, *Final Medical Loss Ratio Rule Rebuffs Insurance Agents*, KAISER HEALTH NEWS, Dec. 2, 2011, available at <https://khn.org/news/final-medical-loss-ratio-rule-rebuffs-insurance-agents/> (last accessed May 4, 2018).

²⁴⁵ *Id.*

such as marketing, profits, salaries, administrative costs, and agent commissions.”²⁴⁶ Insurance companies that miss the required MLR must provide a rebate to its beneficiaries.²⁴⁷ 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.²⁴⁸

There is no doubt that the MLR seems to have 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 2013.²⁴⁹ Even after the markets were fully functioning, it has continued to save beneficiaries money: in 2015, a total of nearly 1.2 million beneficiaries received MLR rebates totaling \$107.3 million, according to Kaiser.²⁵⁰ The regulatory “floor” that the ACA’s MLR provision imposed undoubtedly improved the financial efficiency of health insurance.²⁵¹

But, it has also had other effects. Most basically, 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,²⁵² 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 to begin.

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 insurance company—the only actor in the health care delivery system that is purportedly incentivized

²⁴⁶ *Medical Loss Ratio (MLR)*, healthcare.gov, available at <https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/> (last accessed May 4, 2018).

²⁴⁷ See *Medical Loss Ratio*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html> (last accessed May 4, 2018).

²⁴⁸ *The Gaming Begins*, Editorial, N.Y. TIMES, May 23, 2010, available at <https://www.nytimes.com/2010/05/24/opinion/24mon2.html> (last accessed May 4, 2018).

²⁴⁹ See Hudson, *supra* note 239.

²⁵⁰ See *Medical Loss Ratio (MLR) Rebates in the Individual Market for Consumers and Families*, KAISER FAMILY FOUNDATION, available at <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 accessed May 5, 2018).

²⁵¹ See Kliff, *supra* note 237 (noting that, prior to the ACA MLR, some individual health insurance plans “would spend as little as 60 percent on medical costs”).

²⁵² *Id.*

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—by statute. No matter how you slice it, twenty percent of a smaller pie is a smaller number.

Put another way, an insurance company that wishes to grow its overall profit—not the *percentage* of profit it is allowed to pocket in the ACA marketplaces, but the gross amount of profit—is actually *incentivized* to raise its premiums. Because there is no limit on the amount premiums can increase on an annual basis, but 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.²⁵³

There is a clear response to this concern: in the private marketplace, insurance companies that fail to hold down premium increases effectively will hemorrhage 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 their 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 even in an MLR regime 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 woefully under-competitive, (2) the health insurance consumer is not price-sensitive, (3) the individual market contemplates legally-mandated purchases, and (4) increasingly saturated health care provider markets have already flipped leverage in the provider-insurer relationship. In short, relying on the consumer to prevent the worst excesses of the ACA private exchange market is ineffective.

Under-Competitive Markets. Like an annual ritual, substantial hand wringing has occurred around the concern that whole

²⁵³ See ELIZABETH ROSENTHAL, *AN AMERICAN SICKNESS: HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK*, at __ (Penguin, 2017) (“WellPoint’s first priority appeared no longer to be its patient/members or even the companies and unions that used it as an insurer, but instead its shareholders and investors.”).

counties will soon lack an ACA exchange insurer.²⁵⁴ Even though it has not yet happened,²⁵⁵ the number of counties with just one participating insurer has been striking.²⁵⁶ In fact, in 2018, a majority of counties in the individual marketplace in 2018 (52 percent of all counties)—nonetheless representing where about 26 percent of enrollees live—have one participating insurer on the ACA marketplace.²⁵⁷ Indeed, this percentage is lower than originally projected,²⁵⁸ 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.

Insensitive Consumers. 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.²⁵⁹ Again, the majority of beneficiaries receive subsidies that cover the majority of their health insurance costs,²⁶⁰ weakening their drive to be price-discriminating consumers. Whether or not beneficiaries have enough “skin in the game” is a topic that preoccupies health economists.²⁶¹ However, notwithstanding the perfect calibration

²⁵⁴ See Haeyoun Park and Audrey Carlsen, *For the First Time, 45 Counties Could Have No Insurer in the Obamacare Marketplaces*, N.Y. TIMES, Jun. 9, 2017, available at <https://www.nytimes.com/interactive/2017/06/09/us/counties-with-one-or-no-obamacare-insurer.html> (last accessed May 4, 2018).

²⁵⁵ Dylan Scott, *There Are No More Counties Without Any Obamacare Plans*, VOX, Aug. 24, 2017, available at <https://www.vox.com/health-care/2017/8/24/16199620/voxcare-no-counties-without-obamacare> (last accessed May 5, 2018).

²⁵⁶ See Ashley Semanskee, et al., *Insurer Participation on ACA Marketplaces, 2014-2018*, KAISER FAMILY FOUNDATION, Nov. 10, 2017, available at <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/> (last accessed May 5, 2018).

²⁵⁷ See *id.* (the entire states of Kentucky, Delaware, Hawaii, 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).

²⁵⁸ See Olga Khazan, *Why So Many Insurers Are Leaving Obamacare*, THE ATLANTIC, May 11, 2017, available at <https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/> (“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.”).

²⁵⁹ See Paul Krugman, *Patients are Not Consumers*, N.Y. TIMES, Apr. 21, 2011, available at <https://www.nytimes.com/2011/04/22/opinion/22krugman.html> (last accessed Jun. 27, 2018) (“The idea that all this can be reduced to money—that doctors are just “providers” selling services to health care “consumers”—is, well, sickening.”).

²⁶⁰ See discussion and accompanying text, *supra* note 141-42.

²⁶¹ 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).

of consumer “pain,” any subsidy that helps the many beneficiaries purchasing plans on the ACA individual market lessens the pressure on beneficiaries to be substantially price-discriminating. A consumer who enjoys the fact that more than 80 percent of one’s bill is being covered by the federal government cannot possibly mimic a true consumer, no matter the makeup of the good.

Legally Mandated Purchases. Before the repeal of the individual mandate penalty,²⁶² one could have also pointed to the fact that insurance companies do not feel as beholden to potential beneficiaries, given the fact that consumers have to purchase an insurance plan to avoid the individual mandate penalty. A consumer without a choice as to whether she ultimately makes a purchase cannot be a consumer at all. Given that only 30 percent of Americans know that the penalty was repealed, it may be the case that this dynamic continues to operate into the future.²⁶³

From Adverse to Cooperative. Finally, insurance companies that do not strenuously negotiate, while being more attractive to providers and hospitals, may also—as a byproduct of being less hard-nosed in negotiation—actually *improve* their products by offering larger networks to the beneficiaries who sign up for their plans. Specifically, 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.

C. At the Mercy of Corporate Cooperation

All of the aforementioned characteristics of the health care marketplace contribute to the dysfunction seen on the ACA exchanges. Putting all the idiosyncratic details together, when examining the individual marketplace, the ACA has built a structure that is reliant on what can be called “cooperative corporatism.” Within this idea, 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.

²⁶² See Sanger-Katz, *Requiem*, *supra* note 41.

²⁶³ See Peter Sullivan, *Poll: Just 30 Percent Know ObamaCare Mandate Was Repealed*, THE HILL, Apr. 3, 2018, available at <http://thehill.com/policy/healthcare/381386-poll-just-30-percent-know-obamacare-mandate-was-repealed> (last accessed Jun. 25, 2018).

As a result, the federal government and state insurance commissioners throughout the country have very 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. Instead of the federal government holding the leverage over insurance companies, the markets have been organized the other way around. The government becomes an involuntary partner to all of the price increases, having no ability to challenge them, but on the hook for funding the tax subsidies. Corporate appeasement, needless to say, seems like disastrous policy for cost control.

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 and not the providers or sellers, allowing the state to effectively hold down the price of health care.²⁶⁴ In the United States under the ACA, however, the state has too little leverage in its attempts to ensure insurance companies participate in the markets²⁶⁵—to say nothing of its ability to impact the *pricing* of those plans.²⁶⁶

Through its focus on structural access and its relative inattention to cost control, the ACA's individual market sits on a shaky foundation, one that has been the repeated target for repeal and degradation. The precariousness with which the individual marketplace endures has nonetheless put other pieces of the ACA at

²⁶⁴ See Groopman and Hartzband, *supra* note 28 (“Many 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, available at <https://www.nytimes.com/2017/01/23/health/the-fight-trump-faces-over-drug-prices.html> (last accessed Jun. 25, 2018) (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 REPORTS, Sept. 2014, available at <https://www.consumerreports.org/cro/magazine/2014/11/it-is-time-to-get-mad-about-the-outrageous-cost-of-health-care/index.htm> (last accessed Jun. 25, 2018) (Medicare “is by far the largest single source of revenue for most health care providers, which gives it more leverage to set prices.”).

²⁶⁵ See Khazan, *supra* note 258.

²⁶⁶ See Holly Fletcher, *Tennessee Insurance Commissioner: Obamacare Exchange “Very Near Collapse,”* TENNESSEAN, Aug. 23, 2016, available at <https://www.tennessean.com/story/money/industries/health-care/2016/08/23/insurers-get-approval-for-2017-obamacare-rates/89196762/> (last accessed Mar. 29, 2018) (noting that the Tennessee Insurance Commissioner signed off on rate increases of 62 percent, 46 percent, and 44 percent 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”).

near-constant risk. Indeed, the repeal effort—which coalesced around the American Health Care Act in May of 2017—focused much of its energy on gutting the Medicaid program, but leaving the husk of the ACA intact.²⁶⁷ What is true, of course, is that substantial political unpopularity of any one part of the ACA drags down other parts of the law, putting the entire project at risk.²⁶⁸ Given what is at stake, those who gained access from the expansion of the Medicaid program should have been highly aware of the enduring political hostility toward the individual mandate.

D. Resulting Socioeconomic Chafing

Seemingly one of its benefits, but increasingly one of the consequences of the ACA’s individual marketplace, is its bedrock design that the law treats individuals in different income brackets radically differently. Tightly calibrated, the ACA’s individual marketplace is heavily subsidized, with those low earners earning the largest subsidies. The subsidy structure is a technocratic marvel, applying a sliding scale up the income scale, in an attempt to meet individuals in very different socioeconomic realities in different places.

But the ACA’s subsidy structure has major cliffs between individuals. For example, based upon projected website calculations, a married couple seeking health insurance on the ACA exchange with a \$60,000 household income would receive \$979 per month in subsidies and pay about \$478 per month out-of-pocket for health insurance premiums.²⁶⁹ The same couple with a \$70,000 household

²⁶⁷ See Robert Pear and Thomas Kaplan, *Senate Health Care Bill Includes Deep Cuts to Medicaid*, N.Y. TIMES, Jun. 22, 2017, available at <https://www.nytimes.com/2017/06/22/us/politics/senate-health-care-bill.html> (last accessed May 22, 2018) (“The Senate measure, like the House bill, would phase out the extra money that the federal government has provided to states as an incentive to expand eligibility for Medicaid. And like the House bill, it would put the entire Medicaid program on a budget, ending the open-ended entitlement that now exists.”).

²⁶⁸ Beyond its access provisions, the ACA made additional changes around how Medicare pays for health care—improving incentives for that program—through value-based purchasing. See Elizabeth Whitman, *Fewer Hospitals Earn Medicare Bonuses Under Value-Based Purchasing*, MODERN HEALTHCARE, Nov. 1, 2016, available at <http://www.modernhealthcare.com/article/20161101/NEWS/161109986> (last accessed May 22, 2018) (“The Hospital Value-Based Purchasing program went into effect in October 2012. It was established under the Affordable Care Act as one of many initiatives to pay for healthcare on the basis of quality, not quantity.”).

²⁶⁹ See *Health Insurance Marketplace Calculator*, KAISER FAMILY FOUNDATION, Nov. 3, 2017, available at <https://www.kff.org/interactive/subsidy-calculator/#state=tn&zip=37922&locale=Knox&income-type=dollars&income=60000&employer-coverage=0&people=2&alternate-plan-family=individual&adult-count=2&adults%5B0%5D%5Bage%5D=30&adults%5B0%5D%5Btobacco%5D=0&adults%5B1%5D%5Bage%5D=30&adults%5B1%5D%5Btobacco%5D=0&child-count=0> (last accessed May 23, 2018).

income would receive no federal tax subsidy, and would have to pay approximately \$1,457 per month in healthcare premiums.²⁷⁰ As a result, the couple making \$60,000 per year, would pay \$5,736 annually in health care premiums; the couple making \$70,000 per year would pay \$17,484 annually. In effect, then, the lower-earning couple would actually come out on top after health care premiums were paid, in a bizarre example of the exchange's aggressive income cliffs.

This asperous fragmentation has led to helplessness,²⁷¹ resentment,²⁷² and frustration²⁷³ 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 in the Affordable Care Act, but we don't have time to start over from scratch. We are suffering now.'²⁷⁴

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 undoubtedly painful.

²⁷⁰ *Id.*

²⁷¹ See Robert Pear, *Middle-Class Families Confront Soaring Health Insurance Costs*, N.Y. TIMES, Nov. 16, 2017, available at <https://www.nytimes.com/2017/11/16/us/politics/obamacare-premiums-middle-class.html> (last accessed May 23, 2018).

²⁷² See Rovner, *supra* note 147 ("We're getting slammed. We didn't budget for this."); Goodnough, *supra* note 23 ("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.'"); Rosenthal, *supra* note 214 ("Yet even as many beneficiaries acknowledge that they might not have insurance today without the law, there remains a strong undercurrent of discontent.").

²⁷³ See, e.g., Catherine Keefe, *I'm an Obama Supporter. But Obamacare Has Hurt My Family.*, WASH. POST, Dec. 10, 2014, available at <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/> (last accessed May 23, 2018).

²⁷⁴ Pear, *supra* note 271.

But what makes the pain worse is that not everyone—even those in a nearby socioeconomic neighborhood—is experiencing it. The craggy cutoffs between various financial cadres of households are often seen as draconian and irrational state-based line drawing. Ms. Hurd exemplifies this resentment 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.”²⁷⁵ What is true, of course, is that forcing most Americans to pay their “fair share” for their health care would be completely unsustainable.

But what is frustrating is a perception of unfairness because seemingly so many others are getting assistance.²⁷⁶ And that, of course, is true.²⁷⁷ Structural access without sustainability has propagated resentment, which gives way to political efforts to destroy the positive structural gains made by the law.

For sure, Hurd’s beliefs are representative of a real cost of the law. Other political reporters have found the same ferment.²⁷⁸ While 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 better, even cheaper benefits—and those other people did not deserve the help.”²⁷⁹ Whether these beliefs are right or wrong, decent or

²⁷⁵ Goodnough, *supra* note 23.

²⁷⁶ *Id.* See Tami Luhby, *Why So Many People Hate Obamacare*, CNN, Jan. 6, 2017, available at <http://money.cnn.com/2017/01/05/news/economy/why-people-hate-obamacare/index.html> (last accessed May 23, 2018) (quoting a “financial adviser from Lexington, Virginia,” as saying, “‘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.’”).

²⁷⁷ See Discussion and accompanying notes, *supra* nn. 269-75.

²⁷⁸ See Sarah Kliff, *Why Obamacare Enrollees Voted for Trump*, VOX, Dec. 13, 2016, available at <https://www.vox.com/science-and-health/2016/12/13/13848794/kentucky-obamacare-trump> (last accessed May 23, 2018). 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.

²⁷⁹ *Id.*

indecent,²⁸⁰ 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, many* Americans have trouble paying for it, this surely can breed resentment against the law that does so much good for so many.²⁸¹

E. Political and Regulatory Degradation

In an easy logical jump, financial pain, socioeconomic chafing, and more unbridled resentment can very easily slide into political degradation. The truth is, the ACA has not enjoyed clear public support since its implementation.²⁸² This, among other characteristics, has been a particularly troublesome feature of a law that most policy experts thought would be popular.²⁸³ That it took a direct frontal

²⁸⁰ See Caitlin Dewey, *White America's Racial Resentment Is the Real Impetus for Welfare Cuts, Study Says*, WASH. POST, May 30, 2018, available at <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/> (last accessed May 31, 2018) (“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.”).

²⁸¹ In this way, the ACA played in to the 2016 Presidential Election in astounding ways. See Arlie Hochschild, *STRANGERS IN THEIR OWN LAND* (The New Press, 2016); Jason DeParle, *Why Do People Who Need Help From the Government Hate It So Much?*, N.Y. TIMES, Sept. 19, 2016, available at <https://www.nytimes.com/2016/09/25/books/review/strangers-in-their-own-land-arlie-russell-hochschild.html> (last accessed May 23, 2018) (“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.”).

²⁸² See Jim Norman, *Affordable Care Act Gains Majority Approval for First Time*, GALLUP, Apr. 4, 2017, available at <http://news.gallup.com/poll/207671/affordable-care-act-gains-majority-approval-first-time.aspx> (last accessed May 23, 2018) (according to Gallup, approval bounced between 37 and 48 percent between early 2013 and late 2016; in April 2017, 55 percent supported the law); *Kaiser Health Tracking Poll: The Public's Views on the ACA*, KAISER FAMILY FOUNDATION, May 10, 2018, available at <https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=all> (last accessed May 23, 2018) (showing support for the ACA exceeding 50 percent for the first time in May of 2017).

²⁸³ See Ezra Klein, *Obamacare's Most Popular Provisions Are Its Least Well Known*, WASH. POST, Mar. 22, 2013, available at https://www.washingtonpost.com/news/wonk/wp/2013/03/22/obamacares-most-popular-provisions-are-its-least-well-known/?utm_term=.9a208d0c79f8 (last accessed Jun. 25, 2018) (“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.”).

assault in early 2017 to finally pull the law over 50 percent approval should be telling.²⁸⁴ Unsurprisingly, polling on removing the individual mandate penalty was split nearly completely in half in early 2017.²⁸⁵ This, of course, has continued to place its long-term stability at risk, and had led Republicans to strive to repeal president Obama’s signature piece of legislation for the better part of a decade.²⁸⁶ In the environment where political support is not robust, the ACA’s survivability becomes a daunting proposition.

Relatedly, the law is not threatened only by political degradation, but also by regulatory degradation. In short, 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. In its simplest terms, since the government is *both* interested in expanding the number of individuals who have insurance *and* responsible for regulating—and theoretically, penalizing—insurance plans that deviate from the strictures of the ACA’s rules, for the government—typically though HHS—it may quickly be the case that one interest inextricably conflicts with the other. For instance, if the government’s interests in adequately policing the individual exchange marketplace shrinks the number of plans for sale on those exchanges, it may ultimately harm its interest in achieving universality.

This is most clearly presented by the scenarios in which insurance companies seek to win approval of rate increases. In many states’ exchange markets which feature few competitors, state insurance commissioners have little ability to decline proposals to increase premiums. And when carried to its extreme, this degrades the entire regulatory regime.

IV. A SHIFT: PRIVATIZING PUBLIC ACTORS

By seeking to leave room for private market actors within the individual health insurance exchanges, the ACA adopted a model that has tracked health care law and policy for the better part of the last century: an unwavering commitment to the private market’s ability to fairly provide health insurance, but with government-imposed regulatory guardrails. The ACA supercharged this model, however, in

²⁸⁴ See Norman, *supra* note 282.

²⁸⁵ See Jennifer Agiesta, *CNN/ORC Poll: Public Splits on Revoking Individual Mandate*, CNN, Mar. 7, 2017, available at <https://www.cnn.com/2017/03/07/politics/health-care-replacement-poll/index.html> (last accessed May 23, 2018).

²⁸⁶ See Juliet Eilperin, et al., *Senate Republicans’ Effort to ‘Repeal and Replace’ Obamacare All But Collapses*, WASH. POST, Jul. 18, 2017, available at 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 (last accessed Jun. 25, 2018) (noting a “seven-year” quest to repeal the law).

that it lured private insurance companies into a previously unprofitable market (made profitable by generous subsidies) while ratcheting up the regulatory scaffolding around it. It paid private insurance companies to participate while mandating they sign-up citizens with insurance risks they would have never previously accepted.

In short, the government both pushed insurance companies into participating in the markets and pushed patients into purchasing plans on the exchanges. In this way, by increasingly regulating the private product of health insurance, the ACA adopted a posture that sought to domesticate a private actor in hopes it could harness the raw energy of the private marketplace, but constrained it in a fundamental way. What it did not do, however, was look to the government to operate as a smarter purchaser of health care services—something that now continues to hamper a health delivery system that lacks any realistic cost control.

Instead of pushing private insurance companies to submit to a highly-regulated (and thus, more public) system, Congress could have relied on a system that placed the government at the center of administering a delivering health care for those who, to that point, had been deemed uninsurable. While this solution was likely not politically palatable, the ACA still could have built a system that better-empowered the government to act more like a private actor. In this way, options short of a single payer program, or even short of a public option, would have allowed the ACA to incorporate a measure of cost control that it currently lacks.

The ACA could have empowered the federal government to operate as a more prudent purchaser of insurance on its taxpayers' behalf. As one example, instead of providing premium-assistance tax credits to consumers purchasing insurance plans, it could have imposed a "tiered" subsidies plan, so as to reward efficient insurance companies by paying more substantial subsidies to those who hold down premium increases. The key here would be incentivizing insurance companies to minimize the costs of premiums—something that currently does not exist within the law. The federal government could rely on a systematic solution of "managed exchanges," or "smart subsidies," where it provided an important impetus for insurance companies to offer more efficient insurance plans. Instead of subsidizing consumer-patients based on their household income, the subsidies could move toward subsidizing the insurance plans—and evince a clear policy choice for those plans that operate in a leaner way.

This, in some ways, would add the successful tools of managed care to the exchange marketplaces, mirroring some of the same policy goals as Medicare's Shared Savings Program (MSSP), a payment regime in which the doctors and facilities share in savings achieved under new payment models within Medicare. With the government holding purse strings necessary to keep these markets viable, it should

feel empowered to use that leverage in a more effective way. Since the government is largely funding the insurance marketplace, perhaps it should be more intentional about the types of products it rewards.

Further, mirroring the subsidies seen in the food and housing contexts, the ACA could use its public subsidies as a foothold to impose more stringent cost controls on insurance companies. After all, with the public propping up the markets, it surely has the ability to use its investment to make the markets work better for millions of beneficiaries. In addition to simply relying on the MLR, the federal government could impose other, more targeted regulatory tools that push insurance companies to be swayed by other incentives— incentives that hold down costs.

For example, the ACA could better-calibrate its subsidies. Drawing on scholarship examining the right amount of “skin in the game” to prevent the documented problem of moral hazard,²⁸⁷ perhaps new regulations could limit deductible to a *percentage of one’s income*. This would alleviate the problem of individuals feeling as though their deductibles are so expansive that they cannot afford to access health care.

As another example, perhaps beneficiaries could be *paid* to access preventive care. Long understood to be a major source of cost savings for insurance companies, building a system that better incentivizes citizens to access services may be policy solutions worth pursuing. A more basic idea would be to simply smooth out the income cutoffs in an effort to prevent the cliffs that impact people’s perceptions of, and experiences with, the law. These and other policy tweaks that seek to make the markets more efficient and impose modest cost-control tools could be implemented with a big upside for the functionality of the markets.

CONCLUSION

That the ACA is both still substantially intact and remains under existential threat is yet another example of America’s intractable health care dichotomy. For generations, Americans have been skeptical of government involvement, but uncomfortable with only 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 a bloated and under-regulated non-system, one that continues—even after the ACA—to prove its unworkability for millions of Americans.

²⁸⁷ See Pauline Bartolone, *When High Deductibles Cause Patients to Postpone Care*, CNN, Aug. 5, 2017, available at <http://money.cnn.com/2017/08/05/news/economy/high-deductibles-insured-health-care/index.html> (last accessed Jun. 25, 2018); Robertson, *supra* note 261.

Seen by some as a turn away from the chaotic decades that proceeded it, the ACA actually more tightly instantiated the very dichotomous footers that dominated health care before its creation. And its failure to boldly push American health care into a new place may ultimately prove to be its undoing. As it teeters on the brink, one cannot help but think it was infected by the virus it was initially trying to cure, its noble but naïve attempt at universality and its moderate and humble goals of structural access buried by the appetite of a poorly calibrated private market.