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Employment-Based Health Insurance: Is Health Reform a "Game Changer?"

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Abstract

Employment-based health insurance is the Rodney Dangerfield of health policy: it gets no respect. Prominent health policy scholars and the media routinely condemn the linkage between employment and health insurance. Liberals view the existence of employment-based coverage ("EBC") as the major stumbling block to instituting a one-payer system. From the opposite end of the political spectrum, free market enthusiasts attack EBC for distorting decisions about employment and coverage, and obscuring the true cost of health care. Employers are lukewarm about their role in the health insurance market; as the former head of General Motors aptly observed, "when I joined GM 28 years ago, I did it because I love cars and trucks. I had no idea I'd end up working as a health care administrator."

EBC may not get much respect, but it is a fundamental and long-standing reality of American health policy. Approximately 160 million Americans obtain their health insurance through their place of employment, or the place of employment of an immediate family member. This article explains how EBC became such an important part of American health policy, and evaluates the likely impact of the Patient Protection and Affordable Care Act of 2010 ("PPACA") on EBC. It concludes that PPACA is likely to have a range of unintended consequences.

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[1] Richard & Marie Corman Professor of Law and Professor of Medicine, University of Illinois. I appreciate the helpful comments I received from Charlie Silver and Bill Sage.

Employment-Based Health Insurance Coverage:
Is Health Reform a "Game Changer?"

I. Introduction

As I have noted previously, employment-based health insurance is the "Rodney Dangerfield of health policy: it gets no respect from anyone."[2] Prominent health policy scholars and the media routinely condemn the linkage between employment and health insurance. Liberals view the existence of employment-based coverage ("EBC") as the major stumbling block to instituting a one-payer system (more recently positioned as "Medicare for All" and the "public option.") From the opposite end of the political spectrum, free market enthusiasts attack EBC for distorting decisions about employment and coverage, and obscuring the true cost of health care. Employers are lukewarm about their role in the health insurance market; as the former head of General Motors aptly observed, "when I joined GM 28 years ago, I did it because I love cars and trucks. I had no idea I'd end up working as a health care administrator."[3]

EBC may not get much respect, but it is a fundamental and long-standing reality of American health policy. Approximately 160 million Americans obtain their health insurance through their place of employment, or the place of employment of an immediate family member. The balance of this article explains how EBC became such an important part of American health policy, and considers the likely impact of the Patient Protection and Affordable Care Act of 2010 on EBC. Part II provides a basic primer on EBC. Part III explains how employers got into the business of providing health insurance coverage, and the factors that have kept them in that market. Part IV outlines the provisions in PPACA that affect EBC, and considers what their impact is likely to be. Part V concludes.

II. EBC 101

Pre-PPACA, most employers in most states had complete freedom to decide whether or not to offer EBC.[4] The decision to offer coverage was economically

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[2] David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001). For additional background on EBC, see Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*, HEALTH AFF., Oct. 21, 2008, at W533, http://content.healthaffairs.org/cgi/content/abstract/27/6/w533 (published online only); Alain C. Enthoven and Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, 25 HEALTH AFF. 1538 (2007); David Blumenthal, *Employer-Sponsored Health Insurance in the United States – Origins and Implications,* 355 NEW ENG. J. MED. 82 (2006).

[3] George F. Will, *What Ails GM*, Wash. Post, May 1, 2007, available at http://www.washingtonpost.com/wp-dyn/content/article/2005/04/29/AR2005042901385.html (quoting Rick Wagoner, CEO of General Motors). See also Jeff Jacoby, *GM's Healthcare Dilemma*, Boston Globe, June 16, 2005, available at http://www.boston.com/news/globe/editorial_opinion/oped/articles/2005/06/16/gms_healthcare_dilemma/ ("Is General Motors an automobile manufacturer that provides healthcare benefits for its workers? Or is it a health insurance provider that also happens to make cars?"); Ceci Connolly, *U.S. Firms Losing Health Care Battle, GM Chairman Says,* Wash. Post, Feb. 11, 2005, available at http://www.washingtonpost.com/wp-dyn/articles/A15828-2005Feb10.html.

[4] Hawaii has had an employer mandate since 1974. Massachusetts adopted an employer mandate in 1988, and then repealed it in 1996. Massachusetts subsequently adopted an employer mandate in 2006 (as did

significant; the average annual premium for family coverage in 2009 was $13,375, with the employer directly paying $9,860.[5] From the employer's perspective, the cost of health insurance ranged from 6.8% (non-unionized workers) to 11.8% of payroll (unionized workers) – exceeding the combined spent by employers on Medicare, Social Security, unemployment insurance, and workers compensation, and substantially exceeding the cost of retirement benefits.[6]

Despite this cost, in 2009, roughly 60% of employers offered EBC, with the specific terms and availability varying greatly, depending on employer characteristics.[7] Size does matter; only 46% of employers with 3-9 workers offered EBC, compared to 98% of employers with more than 200 employees.[8] Employers in certain industries (e.g., agriculture, retail, and food service) were quite unlikely to offer coverage. Employers do not necessarily offer coverage to all employees: temporary, seasonal and part-time employees typically did not qualify for EBC. Employers can also decide whether or not to offer coverage to dependents of employees. Conversely, unionized employers are extremely likely to offer EBC, and to offer richer benefit packages (including first-dollar coverage).

What about time trends? As Figure 1 reflects, the last decade has seen moderate erosion of EBC, in response to rising health care costs and larger macroeconomic trends, with the smallest employers showing the largest relative and absolute decline.

Figure 1: Percentage of Firms Offering EBC

Vermont). Oregon adopted an employer mandate, but it expired after Oregon failed to obtain an exemption from ERISA (unlike Hawaii). California adopted an employer mandate in 2003, but it was repealed by voter referendum. Washington adopted an employer mandate in 1993, and it was repealed in 1995.

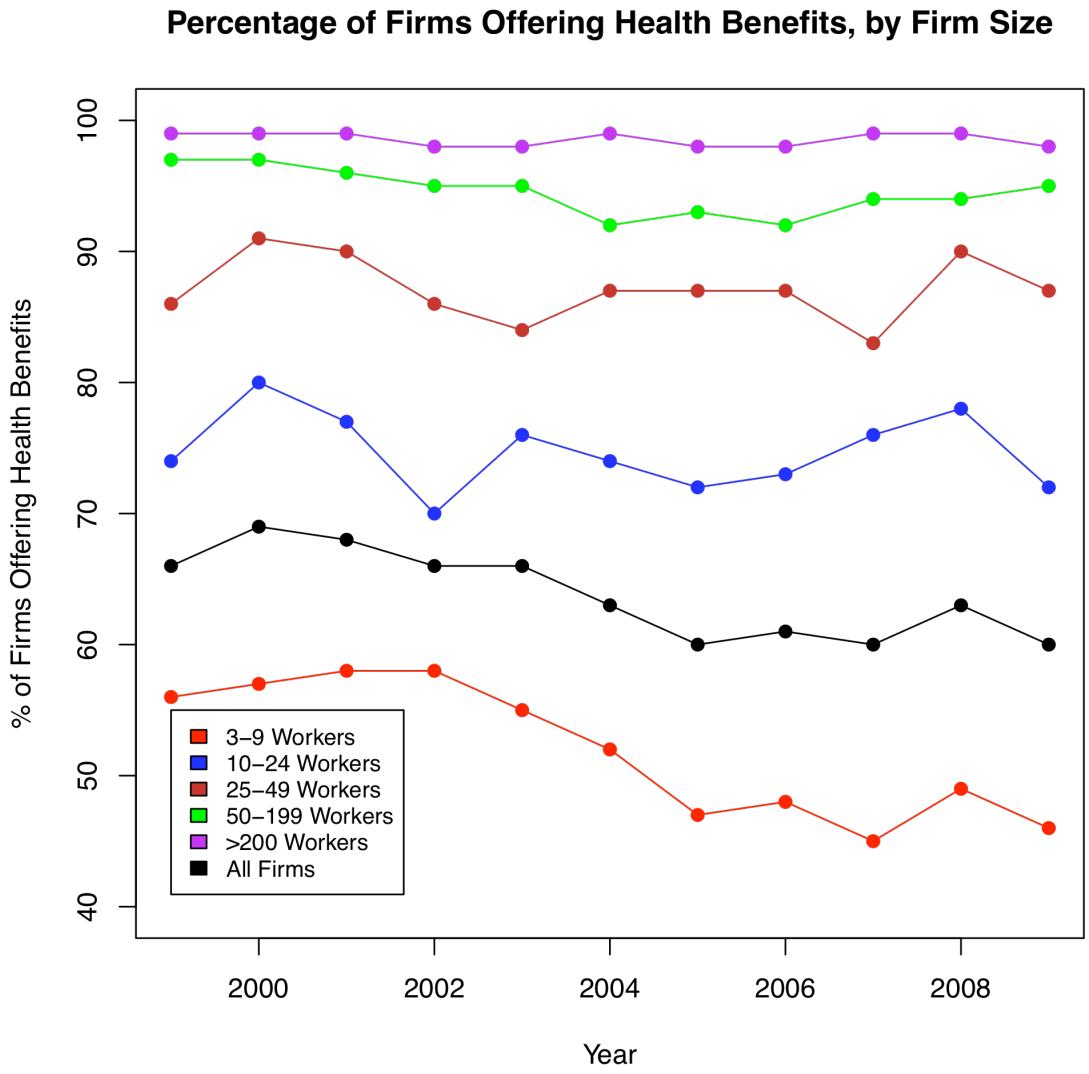
San Francisco also adopted an employer mandate in 2006, but it has been mired in litigation. A cert petition is currently pending before the Supreme Court; the Solicitor General just recommended against review. Finally, Maryland and Suffolk County, New York also enacted employer mandates, but their efforts were struck down by the courts.

[5] Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2009 Annual Survey 1 (Exhibit A) available at http://ehbs.kff.org/pdf/2009/7936.pdf.

[6] Bureau of Labor Statistics (June 10, 2010), 'Employer Costs For Employee Compensation', available at http://www.bls.gov/news.release/pdf/ecec.pdf. See also http://www.bls.gov/ncs/ebs/benefits/2009/benefits.htm

[7] Kaiser Family Foundation, *supra* note 5, at 5 (Exhibit F).

[8] Id.



Source: Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2009 Annual Survey 1 (Exhibit F) available at http://ehbs.kff.org/pdf/2009/7936.pdf.

Of course, the decision to offer coverage (or not) is not the only relevant parameter. Figure 1 does not reflect changes in the breadth and depth of coverage, the number of employees that qualify for coverage, the choice of providers that are "in-network" or "out-of-network," and the degree of point-of-purchase cost to the employee. All of these factors affect "uptake rates," since employees must decide to "opt-in" to coverage in order to receive it. Roughly 20% of those who can obtain employment-based health insurance choose not to do so. Some are covered by a spouse's plan, but many others simply opt not to secure coverage. This phenomenon has increased over the past two decades.

III. Why EBC?

Employers often offer some forms of insurance (e.g., life and disability coverage), but they are not the primary source of such coverage, and other common forms of coverage (e.g., auto, home) are almost never bundled with employment. Why then do employees obtain their health coverage though their place of employment? One can think about this question from a variety of perspectives.

From a functional perspective, employers use EBC to help them attract and retain qualified workers, lower absenteeism, sick pay, and disability costs, and increase productivity. From the employee's perspective, health insurance helps fund necessary health care, promotes health, and protects employees and their dependents from the financial costs associated with ill health.

Employers also offer a functional solution to five distinct problems that employees find it difficult to address by themselves: adverse selection, transaction costs, innovation, bounded rationality, and bargaining leverage. Adverse selection occurs when potential subscribers know more about their individual risks than the insurer knows. If insurers are prohibited from obtaining and acting on that information, the market is likely to unravel, and coverage will become partially or entirely unmarketable. Adverse selection exists to some degree in all insurance markets, and it discourages the purchase of insurance by some people who would otherwise have chosen to purchase coverage. At the extreme, adverse selection may destroy the market altogether, since the tendency is for prices to migrate towards those that are appropriately charged for the highest risks. Obviously, this price point is unaffordable for many -- and a bad deal for most -- potential subscribers.

EBC offers a partial solution to this problem, because the relevant risk pool exists for reasons other than the demand for coverage. Employers are generally not motivated to purchase insurance by specific anticipated health care needs, so the insurer can safely assume that the group's future medical expenses will approximate the group's recent experience. This allows the insurer to assess the overall group's average risk simply by observing its claims experience (experience rating), rather than assessing each individual member's risk. More importantly, group members will not select in or out of the group just because of the insurance, so the group's risk will remain stable. In combination, this means that EBC can be written at a considerably lower cost than would be the case if each member of the pool presented individually and requested coverage.

A second advantage of EBC is that it has lower transaction costs. Instead of having to market and underwrite each individual applicant, the insurer writes a single group policy. The result is substantially lower administrative and marketing costs – particularly if the employer does some of the work of handling enrollment and claims submission with its existing HR staff.[9] Not surprisingly, overhead costs for the largest employer groups are typically five percent or less, whereas these costs reach around 20 percent for smaller groups, and go above 30 percent for individual purchasers.[10]

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[9] As I have noted previously, "medium and large employers. . . have personnel departments, which can cost-effectively handle coverage design, enrollment, premium collection, and dispute resolution. Many employers have developed as much sophistication and expertise in health insurance as that of most insurers," allowing them to "serve as an effective advocate for employees who are involved in coverage disputes.") Hyman & Hall, *supra* note 2.

[10] Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries,* 19 HEALTH AFF. 173 (April, 2000).

A third advantage of EBC is greater flexibility in developing and adopting innovation in coverage and delivery arrangements. Compared to public-sector programs, EBC has far greater flexibility in the design and implementation of cost-cutting and quality-enhancing initiatives. Public sector initiatives typically trigger opposition and lobbying; EBC is (relatively) insulated from such processes.[11]

A fourth advantage of EBC is that employers provide useful search, aggregation and management functions. This process of "informational intermediation" helps compensate for the bounded rationality of individual employees, and ensures that coverage will not be limited to conditions that are salient to employees at the time of purchase. Stated differently, EBC includes benefits that employees might not think to negotiate for, but they would assuredly want if they were rational calculating machines provided with complete information about the probabilities.

Finally, as bulk purchasers, employers can bargain aggressively for discounts. For the same reason that AAA members can obtain lower prices on hotels and restaurants when they travel, employers are able to obtain lower prices (and hence more value) for their employees' money than employees could do on their own.[12]

The question can also be answered from a historical perspective. Prior to World War II, less than 3% of the U.S. population received health insurance through the place of employment. Since 1960, EBC has covered between 60% and 68% of the U.S. population, with a modest downward trend over the last two decades.[13] What explains the rise, dominance, and erosion of employment-based insurance in the U.S.?

The rise of EBC is a historical accident, largely explained by a combination of labor and tax policy. During World War II, the Office of Price Administration imposed wage controls in an attempt to deal with the inflation caused by labor shortages. Compensation paid as cash wages was subject to wage controls, but compensation in the form of fringe benefits was not. Employers accordingly competed for scarce labor talent by enhancing their fringe benefits. Health insurance offered a straightforward way for employers to sweeten their compensation package in a manner that would be appealing to potential employees, but not run afoul of the Office of Price Administration.

As employers ramped up their use of EBC, the Internal Revenue Service issued a ruling in 1943, stating that the amounts paid by employers for insurance for employees did not constitute income to employees. However, employers could deduct these amounts as ordinary and necessary business expenses, and were also not required to count them as wages for purposes of employment tax. The IRS withdrew this ruling in 1953, but Congress quickly reinstated the exclusion.[14] Subsequent amendment made it

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[11] *See* James F. Blumstein and Michael Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH, POLITICS, POL'Y & L. 382, 401 (1979) ("Decentralized choices by nongovernmental decisionmakers. . . has greater potential for precluding symbolic concerns from becoming inextricably involved in policy formulation and will likely point more attention to necessary economic tradeoffs. The design of institutions and policies should therefore take into account the 'susceptibility to symbolic blackmail' of governmental institutions when health issues are directly implicated.")

[12] *See* James Maxwell, Peter Temin, and Corey Watts, *Corporate Health Care Purchasing Among Fortune 500* Firms, 20 HEALTH AFF. 181 (May 2001).

[13] Hyman & Hall, *supra* note 2.

[14] Section 106 of the Internal Revenue Code flatly declares that "gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or

possible for employees to pay for their direct contributions to coverage with pre-tax dollars as well, and allowed self-employed individuals to deduct health insurance premiums to the extent they did not exceed earned income from self-employment.

The result is that employees who obtain EBC (and self-employed individuals who qualify to deduct their premiums) can purchase coverage with pre-tax dollars, while those who obtain insurance through other channels must purchase it with post-tax dollars.[15] The precise amount of the subsidy is a function of the marginal tax rate for any given taxpayer, but because our federal tax system has progressive rates, the benefits of this tax treatment are greater for higher-income taxpayers. The Joint Committee on Taxation estimated in 2009 that this subsidy resulted in foregone taxes of roughly $230 billion.[16] Pre-PPACA, the tax code created a very substantial financial incentive for employees to obtain coverage through their employer if at all possible. Those who would purchase coverage anyway will prefer to receive income in the form of tax-subsidized benefits, instead of as taxable salary – and will prefer richer and broader benefit packages, since an additional dollar of benefits costs them much less than a dollar, with the exact savings dependent on which tax bracket they are in. The "savings" are skewed in a variety of ways, by income level, firm size, and industry sector. There is broad bipartisan consensus that this tax subsidy results in employees receiving an inefficiently high level of health care coverage.

Labor unions were another factor driving the rise of EBC. During the post-war period, unions aggressively bargained for richer benefit packages, with health insurance at or near the top of their list. In industries in which unions were strong (e.g., manufacturing and public-sector employment), the result was that employment-based health insurance became the rule. Employers with non-unionized workforces offered rich benefits to discourage their employees from unionizing. This factor has become less significant with the decline of private-sector unions – although several strikes have resulted from changes in the health insurance offered by private sector unionized employers.[17]

The analysis to this point has focused on the comparative advantages of EBC. Fairness requires an evaluation of the negatives associated with EBC. First, there can be sequencing difficulties when an employee changes jobs. Many health insurance policies

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otherwise) to his employees for personal injuries or sickness."

[15] For individuals who do not receive employment-based health insurance, health care spending (including insurance premiums) is generally deductible only to the extent it exceeds 7.5% of adjusted gross income (AGI). This deduction is available to those who itemize their deductions. For most taxpayers, the standard deduction is larger than their itemized deduction.

[16] Susan Jaffe, Health Affairs, *Health Policy Brief: Tax Debate*, July 9, 2009, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=7 ("Because of the tax exclusion, the amount of forgone income and payroll taxes in 2008 was $226 billion, according to the congressional Joint Committee on Taxation. The Urban Institute's Tax Policy Center estimates next year's revenue loss at $240.5 billion and $3.5 trillion through the next decade. Thus, the tax exclusion for employment-based health coverage is the single biggest subsidy in the federal tax code.").

[17] J.J. Huggins, *No end in sight as Shaw's strike enters 12th week*, Eagle Tribune, May 23, 2010, available at http://www.eagletribune.com/latestnews/x1174306444/Taking-a-stand-against-a-global-giant-No-end-in-sight-as-Shaws-strike-enters-12th-week; Jane Slaughter, *Chicago Teamsters Strike to Save Health Insurance,* Aug. 31, 2009, available at http://labornotes.org/node/2402; Communications Workers of America, *GE Workers to Strike Over Health Care,* Jan. 10, 2003, available at http://www.cwa-union.org/news/entry/ge_workers_to_strike_over_health_care.

contain waiting periods or exclusions on pre-existing conditions, which chill job mobility ('job-lock'), although federal legislation has lowered the frequency and severity of this problem. A worker might also choose to stay in his current job if the substantive terms of insurance coverage are particularly valuable to the worker or his family, even though another job might offer greater opportunities or a higher salary.

A related problem, which the recent economic downturn has highlighted: because coverage is linked to employment, an individual who loses their job simultaneously loses their health insurance coverage. As Professor Uwe Reinhardt cutting noted, "the devil systematically built our health insurance system [which] has the feature that when you're down on your luck, you're unemployed, you lose your insurance. . . only the devil could ever have invented such a system. Humans of goodwill would never do this."[18] The standard estimate is that every 1% increase in unemployment results in 2.1 million Americans losing their EBC.[19]

There are also agency problems with having employers make decisions about coverage for employees. There are predictable disjunctions between the coverage preferences of any given employee and the terms selected by the employer on behalf of the employment-based risk pool as a whole. Some employees might prefer that their insurance cover more extensive postpartum hospitalization, while others might prefer better coverage of AIDS, and some employees might simply prefer less generous coverage in exchange for a higher take-home salary. The distribution of these preferences will also vary from employer to employer; the employees of a start-up software company in Silicon Valley are likely to want a quite different package of benefits than the employees at an automobile assembly plant in Detroit, Michigan.[20] Whatever the choice, the specification of coverage necessarily implies a series of trade-offs within the risk pool, with significant distributional implications within and across identifiable groups.

Changes in coverage design can induce disruption and dislocation costs for employees, with the burdens of those costs disproportionately falling on those with chronic conditions requiring specialized care. Because employers internalize only a portion of the benefits of better quality care, they have less incentive to favor any particular quality enhancement than do employees as a group. Stated more concretely,

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[18] *See* Uwe E. Reinhardt, *Healthcare Crisis: Who's At Risk?*, available at http://www.pbs.org/healthcarecrisis/Exprts_intrvw/u_reinhardt.htm. As I have noted elsewhere, Professor Reinhardt does not consider the possibility that the Devil has a diversified portfolio. *See generally* DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES xviii (2006).

[19] See Kaiser Commission on Medicaid and the Uninsured, Rising Unemployment, Medicaid and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/uninsured/upload/7850_FS.pdf ("Assuming that states maintain eligibility levels for public programs, every one percentage point increase in unemployment is likely to result in one million more Medicaid and SCHIP enrollees and 1.1 million more uninsured.) *See also* Robert Pear, *When A Job Disappears, So Does the Health Care*, N.Y. TIMES, Dec. 6, 2008, at A30.

[20] *See* Catherine C. McLaughlin, *Health Care Consumers: Choices and Constraints,* 56 MED. CARE RES. & REV. 24, 25 (1999) ("While health insurance is but one factor in firm choice, it is not difficult to believe that young, single males may deliberately choose to supply their labor to a small, high-tech firm that offers no health insurance in exchange for higher wages, and that a young male with similar skills but two small children and a wife who does not want to enter the labor market may instead supply his labor to IBM, earning a lower salary, but receiving a rich family health insurance package at a large group rate.")

because plans are a 'bundled' product aimed at a diverse workforce, the alternatives that any given employer offers frequently do not include desired and desirable features from the perspective of any given employee, while also including features an individual employee may regard as a waste of money.

The linkage between employment and health insurance creates one final difficulty. Economists agree that employer contributions are just another form of compensation to employees—and increased costs of coverage in the long run result in smaller wages (and wage increases) for employees. Indeed, the consensus is that rising health care costs swallowed up most of the wage increases that employees would otherwise have received during the past decade. However most employees (and at least some employers) believe that employers are footing the bill for the coverage that employees receive. The result is that employees are relatively indifferent to the cost of their health care coverage (at least to the extent their employer is the one writing the check), while employers are extremely concerned about the cost of providing coverage for their employees. This lack of transparency creates a set-up for conflict between employers and employees about the nature and cost of coverage. It also makes it easy to understand the psychological and budgetary appeal of an employer mandate to legislators and rationally ignorant voters.[21]

To summarize, EBC is a historical accident, attributable to two distinct governmental policies, one of which has long since been scrapped (wage controls), while the other has been expanded (tax subsidy for EBC). Its staying power is probably attributable to a combination of the tax subsidy and the status quo bias, coupled with some of the functional advantages outlined above. But EBC has some real negatives – which explains the demand for reform. To be sure, while it is clear that EBC is imperfect, perfection is not the appropriate standard, unless one accepts the nirvana fallacy.[22] This takes us to the key question; reform is intended to improve things; will PPACA do so?[23]

IV. PPACA

How does PPACA affect EBC? PPACA is a massive piece of legislation, with various components taking effect over the next several years. PPACA also punted many important decisions to the HHS and to other departments (including Treasury, Labor, and

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[21] *See* David A. Hyman, *Employment-Based Health Insurance and Universal Coverage: Four Things People Know That Aren't So*, 9 YALE J. HEALTH POLICY, L. & ETHICS 435 (2009) (explaining the mismatch between popular and academic perceptions about who bears the cost of EBC). *See also* John Oberlander, *The Politics of Paying for Health Reform: Zombies, Payroll Taxes, and The Holy Grail*, HEALTH AFF, Oct. 21, 2008, at w544, w549 http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w544v1 (published online only) ("The (mis)perception that employer-sponsored insurance is paid for by employers remains a large part of employer mandate's political appeal.")

[22] See Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, at 1 (1969) ("The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This *nirvana* approach differs considerably from a *comparative institution* approach in which the relevant choice is between alternative real institutional arrangements."); RICHARD EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD 32 (1995) ("First-best solutions are rarely if ever, possible; thus the beginning of wisdom is to seek rules that minimize the level of imperfections, not to pretend that these do not exist. . .Perfection is obtainable in the world of mathematics, not in the world of human institutions.")

[23] *But see* Norval Morris, *Judicial Conference – Second Circuit – 1978*, 82 FRD 221, 297 (1978) ("Reform, sir, reform? Don't talk to me of reform. Things are bad enough as they are." (quoting Sir Henry Maudsley, the noted British psychiatrist).

Justice), as well as to newly created regulatory bodies. Plus, Congress is likely to revisit individual provisions, as affected constituencies squawk about unintended (and often intended) consequences. These factors make it difficult to make confident predictions about the impact of a statute that has been in effect for only a few months – and has proven considerably less popular than its proponents had hoped and expected. Further, one should be mindful of Yogi Berra's caution, that "its tough to make predictions – especially about the future."

But, I have tenure, so I might as well make some predictions. My predictions are as follows:

(1) *Although voters were promised "if you like your coverage, you can keep it," PPACA is likely to cause further unraveling of EBC, unless significant modifications are made to its design.*

(2) *Pre-PPACA debates were mostly about the on-budget cost of health reform. Post-PPACA, the off-budget cost of PPACA will become far more significant.*

(3) *Unless major cost controls are put into place, we will soon be back in the same position we are in currently.*

I address each of these predictions in turn.

Prediction 1: *Although voters were promised "if you like your coverage, you can keep it," PPACA is likely to cause further unraveling of EBC, unless significant modifications are made in its design.*

During the 2008 campaign, (then Senator) Obama routinely promised "if you like your coverage you can keep it."[24] Even ABC News thought the promise was "not literally true," but Senator Obama had found a winning slogan, and he stuck to it.[25]

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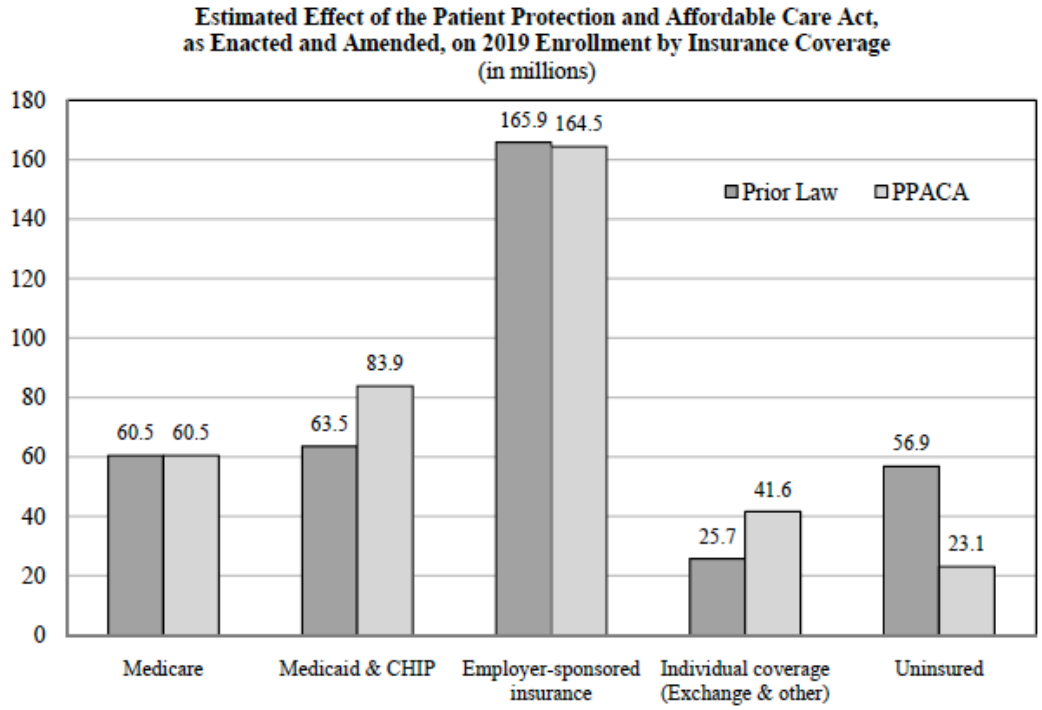
[24] *See, e.g* Obama'08, *Background Questions and Answers on Health Care Plan,* available at http://www.barackobama.com/pdf/Obama08_HealthcareFAQ.pdf ("For those who have insurance now, nothing will change under the Obama plan – except that you will pay less.")

[25] Jake Tapper & Sunlein Miller, *President Obama Continues Questionable "You Can Keep Your Health Care" Promise,* July 16, 2009, available at http://blogs.abcnews.com/politicalpunch/2009/07/president-obama-continues-questionable-you-can-keep-your-health-care-promise.html. *See also* Politifact.com, *Barack Obama promises you can keep your health insurance, but there's no guarantee,* available at http://www.politifact.com/truth-o-meter/statements/2009/aug/11/barack-obama/barack-obama-promises-you-can-keep-your-health-ins/

At the time, the dispute centered on whether a public option would change the dynamics of EBC. It has since metastasized into a broader debate over whether the substantive provisions imposed by PPACA (including but not limited to those described in this article) make that promise illusory, and whether the "grandfathering" provisions are sufficiently robust to rescue some of the promise. *See* Ricardo Alonso-Zaldivar, *Health overhaul to force changes in employer plans,* AP, Jun 11, 2010, available at http://www.breitbart.com/article.php?id=D9G993800&show_article=1 ("Over and over in the health care debate, President Barack Obama said people who like their current coverage would be able to keep it. But an early draft of an administration regulation estimates that many employers will be forced to make changes to their health plans under the new law. In just three years, a majority of workers—51 percent—will be in plans subject to new federal requirements, according to the draft."); Robert Pear, *New Rules on Changes to Benefits,* N.Y. Times, June 14, 2010, available at http://www.nytimes.com/2010/06/14/health/policy/14health.html?ref=robert_pear; Bill Posey, *Most*

President Obama repeated and expanded this claim during the battle over health reform, flatly claiming in a speech to the AMA that, "no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what."[26] A quick glance at a recent report by the chief actuary of the Center for Medicare and Medicaid Services suggests to the unwary reader that this promise has been kept. As Figure 2 reflects, PPACA is projected to have no material impact on the number of Americans that receive EBC.

Figure 2: Effect of PPACA on Coverage



Source: Richard S. Foster, Center for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act,* Apr. 22, 2010, available at

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Americans Will Lose Their Current Health Plans According to Administration's Regulations, June 11, 2010, available at http://www.posey.house.gov/News/DocumentSingle.aspx?DocumentID=190241 ("According to an official draft of the Administration's regulations for implementing the new health care reform law, 51% of all Americans will lose their current health care plans over the next three years. Furthermore, 66% of all employees working for small businesses will lose their current health care plans under the regulations to establish how existing plans will meet the new mandates of the health care reform law."); David Hogberg & Sean Higgins, Keep Your Health Plan Under Overhaul? Probably Not, Gov't Analysis Concludes, Investor's Bus. Daily, June 11, 2010, available at http://www.investors.com/NewsAndAnalysis/Article/537208/201006111932/Keep-Your-Health-Plan-Under-Overhaul-Probably-Not-Govt-Analysis-Concludes.aspx ("

[26] Remarks of President Barack Obama, June 15, 2009, available at http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/2009-annual-meeting/speeches/president-obama-speech.shtml.

https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf

Unfortunately, Figure 2 is quite misleading. Although the estimated number of Americans receiving EBC is projected by CMS to stay almost exactly the same, there is considerable churn underneath the picture of placid stasis. Closer reading indicates that about 14 million Americans are projected to lose their EBC (and 13 million are expected to enroll in EBC) as a result of PPACA. The report goes on to explain the reasons why this is expected to happen:

> [A] number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program or receive subsidized coverage through the Exchanges. For example, some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges. Somewhat similarly, many part-time workers could obtain coverage more inexpensively through the Exchanges or by enrolling in the expanded Medicaid program. Finally, as mentioned previously, the per-worker penalties assessed on nonparticipating employers are relatively low compared to prevailing health insurance costs. As a result, the penalties would not be a substantial deterrent to dropping or forgoing coverage.[27]

The head of the Congressional Budget Office in the Bush Administration has estimated that PPACA could have a far greater adverse impact on EBC, encouraging employers to drop coverage for up to 35 million Americans.[28] The analytical point is simple, although the required computations are exceedingly complex.[29] For low-wage workers PPACA

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[27] Richard S. Foster, Center for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act,* Apr. 22, 2010, available at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf ("Internal administration documents reveal that up to 51% of employers may have to relinquish their current health care coverage because of ObamaCare. Small firms will be even likelier to lose existing plans. The 'midrange estimate is that 66% of small employer plans and 45% of large employer plans will relinquish their grandfathered status by the end of 2013,' according to the document. In the worst-case scenario, 69% of employers — 80% of smaller firms — would lose that status, exposing them to far more provisions under the new health law.")

[28] Douglas Holtz-Eakin & Cameron Smith, *Labor Markets and Health Care Reform: New Results,* American Action Forum, May, 2010, available at http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf

[29] One example of the complexity. Most commentators analyze the value of the tax subsidy for EBC solely in terms of the marginal federal tax bracket of the employee. Yet, the true value of the subsidy is substantially higher, because employer contributions to EBC are not subject to Social Security tax ("FICA") or to state tax. *See* Austin Frakt, *Understanding the Employer Based Insurance Tax Subsidy*, THE INCIDENTAL ECONOMIST, Feb. 3, 2010, http://theincidentaleconomist.com/understanding-the-employer-tax-subsidy (computing that even if "your federal marginal income tax rate is only 20%[,] government (federal and state combined) loses 37 cents of tax revenue for each dollar paid in health insurance as opposed to wage."). As for FICA, see Howard Beck, *As O'Neal's Shadow Fades, Who Will*

provides substantial subsidies for coverage obtained through the exchange, while the tax code provides only modest subsidies for obtaining EBC. For high-wage workers, the subsidy pattern is reversed. After one factors in the penalty employers must pay if employees obtain coverage through the exchange rather than through EBC, it turns out that low-wage workers (i.e., those with incomes < 200-250% of the federal poverty level) and their employers are jointly better off financially if coverage is obtained through an exchange, with the precise cut-off and magnitude of the benefit affected by one's assumptions.

Another provision in PPACA creates an additional incentive for employers to drop coverage; if the coverage they offer is "unaffordable," they must pay an additional penalty. "Affordable" is defined in terms of the percentage of an employee's household income that must be spent on health insurance premiums. According to one survey, roughly one-third of employers had some workers for whom coverage might be "unaffordable."[30]

To be sure, there are limits on the ability of employers to customize their coverage as they might wish in response to these incentives, including anti-discrimination provisions, the complexities of pricing coverage as the size of the pool declines, and employee push-back. The likely result is that some employers will make all-or-nothing coverage decisions for all employees in favor of "nothing," while others will experiment with changing the terms of coverage, and the boundaries of the firm and its staffing. The only thing we can be certain of is that existing arrangements will not prove to be immutable – particularly when there are large subsidies to be gained from unbundling and rebundling of coverage and the workforce. Stated more concretely, the differential subsidies and penalties for EBC v. exchange-based coverage that PPACA has created are likely to prove extremely destabilizing to the continuation of EBC – which, in turn, will dramatically increase the on-budget cost of PPACA.

Those inclined to dismiss this prospect might want to consider various documents that came to light as a result of a recent (April, 2010) investigation by the House Energy & Commerce Committee. After PPACA was enacted on March 23, 2010, numerous companies filed 8-K statements with the Securities & Exchange Commission, alerting investors to the expected adverse financial implications for their operations. Representative Henry Waxman, chair of the House Energy & Commerce Committee promptly fired off letters to four major companies (Verizon, AT&T, John Deere & Caterpillar), requesting documents and testimony from their CEOs, and noting, in the words of the hearing website, "these assertions [of adverse financial impact] appear to conflict with independent analyses, which show that the new law will expand coverage and bring down costs."[31]

Cast the Next One?, N.Y. Times, Feb. 17, 2008, available at http://www.nytimes.com/2008/02/17/sports/basketball/17shaq.html ("Who the hell is FICA? When I meet him, I'm going to punch him in the face.") (quoting Shaquille O'Neal).

[30] Robert Pear, *Study Points to Health Law's Penalties,* N.Y. Times, May 23, 2010, available at http://www.nytimes.com/2010/05/24/health/policy/24health.html.

[31] Byron York, *Democrats threaten companies companies hit hard by health care bill,* Washington Examiner, March 28, 2010, available at http://www.washingtonexaminer.com/politics/Democrats-threaten-companies-hit-hard-by-health-care-bill-89347127.html. See also Energy & Commerce Subcommittee to Hold Hearing on Impact of Health Care Reform Law on Large Employers, available at

The day before the hearing was scheduled, it was cancelled, with the facially absurd excuse that the companies had requested the hearing be delayed until PPACA had been implemented.[32] A memo from the majority staff provided additional background on the decision to cancel the hearing, and is discussed further below.[33] However, the most interesting thing to come to light was not even mentioned in the staff report:

> Nowhere in the five-page report did the majority staff mention that not one, but all four companies, were weighing the costs and benefits of dropping their coverage. AT&T produced a PowerPoint slide entitled "Medical Cost Versus No Coverage Penalty." A document prepared for Verizon by consulting firm Hewitt Resources stated, "Even though the proposed assessments [on companies that do not provide health care] are material, they are modest when compared to the average cost of health care," and that to avoid costs and regulations, "employers may consider exiting the health care market and send employees to the Exchanges." (Under the new bill, employees who lose their coverage will purchase health care through state-run exchanges.)
>
> Kenneth Huhn, vice president of labor relations at Deere, said in an internal email that his company should look at the alternatives to providing health benefits, which "would amount to denying coverage and just paying the penalty," and that he felt he already had the ability to make this change under his company's labor agreement. Caterpillar felt it would have to give "serious consideration" to the penalty option.
>
> It's these analyses -- which show it's a lot cheaper to "pay" than to "play" -- that threaten to overthrow the traditional architecture of health care.[34]

Thus, the documents that were produced indicated that all four companies were "running the numbers" to see whether they would be better off eliminating EBC, thereby forcing their employees to obtain coverage through the exchanges (which won't even exist until 2014).[35] AT&T explicitly stated in its 8-K filing that it was "evaluating prospective changes to the active and retiree health benefits offered by the company" in

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http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1944:energy-a-commerce-subcommittee-to-hold-hearing-on-impact-of-health-care-reform-law-on-large-employers&catid=122:media-advisories&Itemid=55

[32] Memo from Chairmen Waxman & Stupak, April 14, 2010, available at http://energycommerce.house.gov/Press_111/20100414/memo-2.oi.2010.04.14.pdf

[33] Memo from Majority Staff to Chairmen Waxman & Stupak, April 14, 2010, available at http://energycommerce.house.gov/Press_111/20100414/memo.oi.2010.04.14.pdf

[34] Shawn Tully, *Documents reveal AT&T, Verizon, others, thought about dropping employer-sponsored benefits,* CNNMoney.com, May 5, 2010, available at http://money.cnn.com/2010/05/05/news/companies/dropping_benefits.fortune/.

[35] *See* Robert Pear, *Inquiry Says Health Care Charges Were Proper,* N.Y. Times, Apr. 26, 2010, available at http://www.nytimes.com/2010/04/27/business/27health.html ; Jonathan Strong, *Why Waxman really cancelled his health care 'show trial,'* Daily Caller, Apr. 28, 2010, available at http://dailycaller.com/2010/04/28/why-waxman-really-canceled-his-health-care-%E2%80%98show-trial%E2%80%99/?utm_source=MadMimi&utm_medium=email&utm_content=The+DC+Links&utm_campaign=The+DC+Links&utm_term=17_%2529%2BObamacare%2Bdefects%2Bcancel%2BRep_%2BHenry%2BWaxman%2527s%2Bhealth%2Bcare%2B%2527show%2Btrial%2527;

response to PPACA.[36] Verizon also sent a letter to its employees "suggesting that changes to their health plans could be afoot."[37] The work papers that were provided indicated that two of the companies (AT&T and Caterpillar) would save staggering amounts of money by dropping coverage.[38] As Representative Joe Barton cuttingly noted after reviewing the supporting documentation provided by the companies, "from a financial standpoint, from a purely economic standpoint, many companies would be better off discontinuing health care as a fringe benefit, paying the penalty and pocketing the savings."[39]

To be sure, several of the functional reasons for employer involvement in EBC are not changed by PPACA. And, pre-PPACA surveys indicated little interest among employers in taking the radical step of simply dropping EBC.[40] But that was before PPACA changed the incentive structure, and set an explicit fine on withdrawal from EBC. The Obama Administration has explicitly embraced behavioral economics, and used it to frame several provisions in PPACA.[41] Ironically, the Administration appears to have completely ignored the behavioral economics prediction that employers would treat a "fine as a price."[42]

Prediction 2: *Pre-PPACA debates were mostly about the on-budget cost of health reform. Post-PPACA, the off-budget cost of PPACA will become far more visible, and far more significant.*

During the Congressional debates and political maneuvering over PPACA, the focus was always on how the Congressional Budget Office ("CBO") had scored the latest

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[36] Jeffrey Bartash, *Big Employers Rethink Their Healthcare Plans,* L.A. Times, Mar. 27, 2010, available at http://articles.latimes.com/2010/mar/27/business/la-fi-att27-2010mar27

[37] Id.

[38] Tully, *supra* note 34 ("Caterpillar and AT&T actually spell out the cost differences: Caterpillar did its estimate in November, when the most likely legislation would have imposed an 8% payroll tax on companies that do not provide coverage. Even with that immense penalty, Caterpillar stated that it could shave $25 million a year, or almost 10% from its bill. Now, because the $2,000 is far lower than 8%, it could reduce its bill by over 70%, by Fortune's estimate. Caterpillar did not respond to a request for comment. AT&T revealed that it spends $2.4 billion a year on coverage for its almost 300,000 active employees, a number that would fall to $600 million if AT&T stopped providing health care coverage and paid the penalty option instead. AT&T declined comment.")

[39] Pear, *supra* note 35.

[40] *See* Kaiser, *supra* note 5, at 186 (Exhibit 13.2) (documenting little interest among employers in dropping coverage entirely, regardless of size, with 86% of firms saying it is "not at all likely.") See also Towers Watson, *Health Care Reform,* May, 2010, available at http://www.towerswatson.com/assets/pdf/1935/Post-HCR_Flash_survey_bulletin_5_25_10(1).pdf (post-PPACA survey finding little interest in dropping coverage).

[41] On the Obama Administration's enthusiasm for behavioral economics, *see* Michael Grunwald, *How Obama is Using the Science of Change,* Time, Apr. 2, 2009, available at http://www.time.com/time/printout/0,8816,1889153,00.html. There is some indication that the enthusiasm for behavioral economics is waning. See Jonathan Weisman, *Economic Policy Nudge Gives Way to Shove,* Wall St. J. March 8, 2010, available at http://online.wsj.com/article/SB10001424052748704869304575103980232739138.html.

PPACA authorizes employers to use an opt-out strategy for EBC, instead of the opt-in strategy that has prevailed at most employers. A similar approach is authorized for CLASS.

[42] Uri Gneezy & Aldo Rustichini, *A Fine is a Price,* 29 J. Leg. Stud. 1 (2000).

proposal.[43] An "unfavorable" CBO score (i.e., above the roughly $900 billion cost identified by President Obama) meant the legislation was a non-starter. After considerable reverse engineering, PPACA incorporated a wide array of design features explicable only in terms of their ability to game the CBO budget process and its ten year budget window. These included front-loading of the taxes; back-loading of the benefits, excluding the costs of fixing the Medicare physician payment system; assuming cuts in Medicare that are unlikely to materialize; assuming a future Congress will allow the 40% excise tax on high-value benefits to take effect when the current Congress deferred its effective date; and my personal favorite, counting the revenue from a new voluntary long-term care insurance program (CLASS Act) as deficit reducing in the first decade of PPACA, even though those amounts must be paid out in the second decade, and the program is so actuarially unstable that the Chief Actuary of CMS warned before the program even began collecting premiums that there was a "very serious risk that the problem of adverse selection will make the. . . program unsustainable."[44]

Regardless of one's views on the accuracy and validity of the CBO's scoring of PPACA, the key point is that the CBO only focuses on the on-budget costs of health reform. To the extent costs are off-budget, they simply do not appear in the CBO's computations. Thus, my second prediction is that the off-budget costs of PPACA are likely to become far more significant (and far more controversial) than the on-budget costs as PPACA's provisions are implemented.

Consider one leading indicator of likely future controversies. A little noticed provision in PPACA changed the subsidy for employers that provided prescription drug coverage to their retirees (and thus kept those retirees out of Medicare Part D, lowering the on-budget costs of the program). Pre-PPACA, employers received a subsidy of 28% of the cost of providing prescription drug coverage, but were allowed to deduct the full cost of the coverage (including the dollar value of the subsidy they had received). Post-PPACA, employers were not allowed to deduct the subsidy (i.e., they were only allowed to deduct their actual out-of-pocket costs for coverage). To be sure, in deciding whether to continue to provide retiree coverage, the ultimate cost to the employer was the material issue; employers were almost certainly indifferent whether they received a 28% subsidy which they could deduct along with their own expenditures, or a larger subsidy which they could not deduct.

Once PPACA changed the tax treatment of the subsidy, numerous companies promptly filed 8-K statements with the SEC, noting the adverse financial consequences of PPACA on their operations. The dollars involved were impressive; as Table 1 reflects, a benefits consulting firm (Towers Watson) came up with an aggregate impact of $14 billion, with AT&T and Verizon accounting for almost $2 billion of the total.[45]

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[43] *See* Ezra Klein, *The Number Cruncher in Chief*, AM. PROSPECT, Jan. 14, 2009, http://www.prospect.org/cs/articles?article=numbercruncherinchief ("How much a bill costs is central to whether it gets enacted. And not just how much it costs but *how much the CBO says it costs*.")

[44] Foster, *supra* note 27, at 15. A working group of the American Academy of Actuaries and Society of Actuaries came to a similar conclusion almost a year earlier regarding an earlier version of CLASS. *See* American Academy of Actuaries, Letter to Senate Committee on Health, Education, Labor and Pensions, July 22, 2009, available at http://www.actuary.org/pdf/health/class_july09.

[45] *The ObamaCare Writedowns,* Wall St. J., Mar. 27, 2010, available at http://online.wsj.com/article/SB10001424052748704100604575146002445136066.html

Table 1: 8-K Disclosures of Adverse Financial Impact of PPACA

Company	Amount
AT&T	$1 billion
Verizon	$970 million
Deere & Co.	$150 million
Boeing	$150 million
Caterpillar	$100 million
Prudential Financial	$100 million
Towers Watson Estimate	$14 billion

There was immediate and vigorous push-back from the Obama Administration. Secretary of Commerce Gary Locke, who had previously shown neither interest nor expertise in analyzing actuarial predictions posted a defense of PPACA on the White House blog,[46] and then went on television and declared that the charges were "premature and irresponsible."[47] Secretary Locke's remarks ignored the fact that the chief financial officers of ten major corporations had sent a letter four months earlier, warning that PPACA would cause "large earnings statement reductions due to U.S. GAAP income tax accounting rules, which would require employers to immediately account for the present value of this tax increase."[48]

As noted previously, Representative Waxman also announced an immediate investigation, and scheduled a hearing at which CEOs were expected to appear. The hearing was cancelled after House staffers completed a report finding that "the companies acted properly and in accordance with accounting standards in submitting filings to the SEC in March and April."[49] The report hastily added that the reports reflected the present value of an adverse financial impact that would be incurred over decades, and that "if the new law is implemented correctly, the overall impact of the law on large employers could be beneficial."[50] To date, Secretary Locke has not corrected his irresponsible accusation that the charges were "premature and irresponsible."

Why do I recount this incident? Because, it reflects the reality that on-budget expenses are not the whole picture – and both on-budget and off-budget costs will matter going forward. The Obama administration and Rep. Waxman pushed back hard against these companies because PPACA had been sold as deficit (and maybe even cost)

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[46] Gary Locke, Health Reform and America's Businesses: The Bottom Line, Mar. 25, 2010, available at http://www.whitehouse.gov/blog/2010/03/25/health-reform-and-america-s-businesses-bottom-line.
[47] Scott Malone and Nick Zieminski, *Corporate America weighs in on health care costs,* Reuters, Mar. 25, 2010, available at http://www.reuters.com/article/idUSTRE62O3EA20100325
[48] Letter from CFOs of Boeing, Caterpillar, Con-way, Deere & Co., Exelon, Met-Life, Navistar, PSEG, Verizon & Xerox to Senate Majority Leader Reid and Speaker of the House Pelosi, Dec. 11, 2009, available at http://www.americanbenefitscouncil.org/documents/hcr_drugsub_cfo-letter121109.pdf
[49] See Memo From Majority Staff, *supra* note 33.
[50] Id.

reducing – but that was only "true" in the technical sense that it conformed to the CBO's scoring, which had been thoroughly gamed, and counted only the on-budget costs, regardless. Once PPACA had passed, the off-budget costs become far more salient.

Even if one believes the subsidy the companies were receiving for offering retiree drug coverage was too generous, and PPACA was "closing a loophole," the reality is that this incident is merely the first in a series of "realization events" as the off-budget costs of PPACA become apparent. Even with the generous subsidies provided by PPACA, a significant chunk of the cost of obtaining coverage will come in the form of premiums paid by individuals. When that happens, the off-budget (i.e., personal) costs imposed by PPACA are likely to crowd out any discussion of its budgetary impact. In behavioral economics terms, most people are rationally ignorant of the details of the federal budget and of the financing of PPACA, but they are unlikely to be quite so complacent when they have to pay money out of their own pocket.

Prediction 3: *Unless major cost controls are put into place, PPACA will actually make things worse*

PPACA focused on expanding coverage, rather than on cost control. Although PPACA has a variety of provisions attempting to address health care costs, Congress and the Administration had bigger fish to fry. The legislation accordingly focused on broadening access by means of insurance reform and not on changing the incentives driving health care treatment and overall spending. Indeed, on numerous occasions, Congress and the Administration pulled their punches in addressing health care costs – usually by trading stricter reforms in these areas for coverage provisions that they valued more highly.

This is not to suggest that there is nothing in PPACA on cost control. PPACA authorizes a range of pilot programs and demonstration projects to address some of the dysfunctions created by Medicare's encounter-based quality-insensitive fee-for-service payment system. These initiatives are promising, but significantly underpowered and limited in their scope.[51]

In fairness, no one knows for sure which of these initiatives will actually work – but these limitations make it less likely that the proposed payment reform will have any effect whatsoever. History also suggests that Congress will likely cripple or kill

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[51] *See* Ricardo Alonso-Zaldivar, Health care law's unfinished business: cost curbs, Apr. 25, 2010, available at http://finance.yahoo.com/news/Health-care-laws-unfinished-apf-3704361887.html?x=0 ("Many experts believe the law falls short on taming costs, and that will force Congress to revisit health care in a few years. . . Increased demand will push up health care spending, putting more pressure on premiums. The cost controls in the bill are unlikely to provide much of a counterweight. Democrats scrambling to line up votes for the final bill weakened a provision that would have enforced austerity through a hefty tax on high-cost employer coverage. Other savings in the law — mainly Medicare cuts — may prove politically unsustainable, according to the government's own experts. The problem isn't that the 2,700-page law is devoid of ideas for curbing costs. Many mainstream proposals are incorporated in some form. But what will work?. . . 'This bill takes a sort of spaghetti approach to cost control,' said MIT economist Jonathan Gruber, who supports the broad goals of the overhaul. 'You throw a bunch of stuff against the wall and see what will stick. Health care, Round Two, is when we will make a serious effort at cutting costs down, based on what this law has shown us.'" . . . 'Most people who have problems with health care costs now are not going to see much change in the next few years,' said Mark McClellan, who ran Medicare under former Republican President George W. Bush. 'Hopefully some of these ideas will work, but it's not automatic. I do hope we can revisit this in a more bipartisan manner.'")

"effective" initiatives (i.e., those that reduce payments to health care providers), and expand ineffective ones (i.e., those that result in increased payments to health care providers).[52] Although PPACA authorizes expansion of effective pilot projects without further Congressional approval, CMS is likely to be reluctant to do so if it will create hostility in Congress.

What about the Independent Payment Advisory Board ("IPAB"), long hailed as a "game-changer" by OMB Director Peter Orszag?[53] PPACA created an independent, 15-member board charged with presenting Congress and the President with proposals to reduce "excess cost growth" in Medicare. The proposals are fast-tracked for an up or down vote (i.e., they take effect unless Congress passes an alternative measure that achieves the same level of savings). But, IPAB can only trigger fast-track review of their proposals under limited conditions. For example, IPAB cannot make fast-track recommendations about physician and hospital payments (which collectively account for more than half of Medicare spending) until 2019. In addition, IPAB can only make fast-track recommendations if the rate of per capita Medicare spending growth exceeds a fairly high benchmark. There are also serious questions whether IPAB will be able to find personnel with the necessary expertise to fill the 15-member board, since the term is six years, and board members are prohibited from having any other job. Finally, IPAB is prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.[54] More broadly, IPAB faces a daunting challenge: the preconditions for fast-track authority have to be triggered frequently enough and the recommendations have to result in large enough savings to "bend the cost curve" – but they have to do so without creating a political backlash that will cripple or destroy IPAB. Anyone want to place bets on IPAB's ability to thread that needle?

Post-PPACA, academic commentary on the prospects for cost control has been mixed, with optimists promising that cost control will work this time around, and pessimists pointing to the forces that make that outcome unlikely.[55] Why does it matter whether PPACA actually controls costs? Isn't expanding coverage a good thing, in and of itself? Of course it is – but if cost control is not addressed, PPACA will actually make things worse. Don't take my word for it. Just ask President Obama: "If we don't address cost, I don't care how heartfelt our efforts are, we will not get this done. If people think

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[52] *See* Paul Ginsburg, *Comparing the Traditional Medicare Program to Private Insurance*, *Senate Finance Committee*, 1999 WL 300800 (1999) (testimony before the Senate Finance Committee); Bryan Dowd et al., *A Tale of Four Cities: Medicare Reform and Competitive Pricing,* 19 HEALTH AFF. 9, 10 (2000); Len Nichols, *Lessons from the Competitive Pricing Advisory Committee Experience for the Medicare + Choice Program and Long Term Reform*, *Senate Finance Committee*, 2001 WL 316119 (2001) (testimony before the Senate Finance Committee)

[53] *See, e.g.*, Letter from Peter R. Orszag, Director, Office of Management & Budget, to Nancy Pelosi, Speaker of the House of Representatives (July 17, 2009), http://www.whitehouse.gov/omb/assets/blog/Combined_IMAC_docs_-_Package.pdf.

[54] Similar constraints apply to the Outcomes Research Institute (replacing the Federal Coordinating Council on Comparative Effectiveness), initiated with great fanfare and several billion dollars in federal funding.

[55] *Compare* David Cutler, *How Health Care Reform Must Bend the Cost Curve,* 6 Health Aff. 1131 (2010) *with* Douglas Holtz-Eakin & Michael J. Ramlet, *Health Care Reform is Likely to Widen Federal Budget Deficists, Not Reduce Them,* 6 Health Aff. 1136 (2010). *See also supra* note 51.

we can simply take everybody who is not insured and load them up in a system where costs are out of control, it's not going to happen. We will run out of money."[56]

Unfortunately, cost control is the "spinach" that no one wants to eat, while expanding coverage is the "dessert" that everyone prefers to consume. But, one need not be Popeye to think that a steady diet of dessert (or, more optimistically, "dessert first, spinach later, we hope") is unlikely to work out.[57] As I noted in an article about Massachusetts' health reforms, failure to address "the cost of health care . . . will swamp any reform proposal."[58] The early returns from Massachusetts have not been promising, with repeated show-downs between the state, providers, and insurers, proposals for premium caps and price controls, and threatened and actual litigation.[59]

V. Conclusion

American health care has a long and expensive history of rewarding "A," and expecting "B."[60] It hasn't worked out yet, and because PPACA doesn't change the core incentives driving health care spending, it is unlikely that PPACA will be the exception that proves the rule.

The Chinese are reputed to have a curse, "may you live in interesting times." For those of us who do health law and policy and employee benefits, these are likely to prove the most interesting of times.

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[56] President Obama, *Closing Remarks at White House Forum on Health Reform*, March 5, 2009, available at http://www.whitehouse.gov/the_press_office/Closing-Remarks-by-the-President-at-White-House-Forum-on-Health-Reform

[57] David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like Everything Else,* Am. J. L. & Med. (forthcoming, 2010).

[58] David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, 55 KAN. L. REV. 1103, 1115 (2007) ("Finally, the regulations that were adopted do nothing about the cost of health care in Massachusetts – and in the long run, that problem will swamp any reform proposal, including the Massachusetts health plan.")

[59] Hyman, *supra* note 57.

[60] *See* Steven Kerr, *On the Folly of Rewarding A, While Hoping for B,* 9 ACAD. OF MGMT. EXECUTIVE 7, 9 (1995).