

ADDRESS

EVALUATING THE AFFORDABLE CARE ACT: THE EYE OF THE BEHOLDER

*Mark A. Hall**

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)¹ is extraordinary in many ways—not the least of which is how

* Fred and Elizabeth Turnage Professor of Law and Public Health, Wake Forest University.

1. Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S.C.).

ferociously its fate is still being fought, even four years after its enactment. Both legislative and judicial challenges failed,² but the drumbeat of opposition has not relented. “Train wreck.” “The Titanic.” “Obama’s Waterloo.”³ These are just some of the choicer metaphors used by critics to prophesize the ACA’s doom and gloom.⁴

Opponents’ bitterness is not merely sour grapes over the ACA’s survival. Continued harsh criticism is, at least in part, a calculated strategy to undermine the law.⁵ Like authors of a Greek tragedy, many of these prophesiers hope that foretelling the ACA’s demise will make it more likely to come true.⁶ Broad enrollment by healthy people is needed for the ACA to succeed; if

2. See Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608–09 (2012) (holding that the ACA’s individual mandate can be constitutionally construed as a tax); David M. Herszenhorn, *Senate Rejects Repeal of Health Care Law*, N.Y. TIMES, Feb. 3, 2011, at A20 (discussing the majority-Democrat Senate’s rejection of Republican attempts to repeal the ACA).

3. *Conaway Calls Obamacare ‘Train Wreck,’ Votes to Defund Program*, OA ONLINE (Sept. 20, 2013), http://www.oaoa.com/news/us_news/article_9b0b61c8-2219-11e3-b5d6-0019bb30f31a.html; Bryan Koenig, *Debating O’Malley, Perry on Healthcare: Putting More People on the Titanic*, CNN (Sept. 18, 2013, 8:17 PM), <http://politicalticker.blogs.cnn.com/2013/09/18/debating-omalley-perry-on-healthcare-putting-more-people-on-the-titanic/>; Ben Smith, *Health Reform Foes Plan Obama’s ‘Waterloo,’ POLITICO* (July 17, 2009, 12:31 PM), http://www.politico.com/blogs/bensmith/0709/Health_reform_foes_plan_Obamas_Waterloo.html?showall.

4. See, e.g., Tim Murphy, *The Collected Poems of the Affordable Care Act*, MOTHER JONES (Sept. 24, 2013), <http://www.motherjones.com/mojo/2013/09/collected-poetry-affordable-care-act>; Jen Wilson, *NC Lawmaker Bob Rucho Stokes Controversy with Obamacare Tweets*, CHARLOTTE BUS. J. (Dec. 16, 2013, 8:46 AM), <http://www.bizjournals.com/charlotte/blog/morning-edition/2013/12/nc-lawmaker-bob-rucho-stokes-controversy-with.html> (quoting North Carolina Senator Bob Rucho as saying that “Obamacare has done more damage to the USA then [sic] the swords of the Nazis, Soviets & terrorists combined”).

5. See, e.g., Michael F. Cannon, *Obamacare Is Still Vulnerable*, NAT’L REV. ONLINE (Nov. 9, 2012), <http://www.nationalreview.com/articles/333040/obamacare-still-vulnerable-michael-f-cannon> (theorizing that Congress would be forced to reopen Obamacare if enough states strongly opposed it); Michael Tanner, *The States Resist Obamacare*, NAT’L REV. ONLINE (July 4, 2012), <http://www.nationalreview.com/articles/304729/states-resist-obamacare-michael-tanner> (noting that numerous governors have indicated that they would resist the ACA by rejecting the Medicaid expansion); Matthew Yglesias, *The Right’s Obamacare Boycott Will Only Hurt Conservatives*, SLATE (Aug. 13, 2013), http://www.slate.com/articles/business/moneybox/2013/08/obamacare_boycott_conservative_leaders_are_only_going_to_hurt_conservatives.html (“[C]onservative leaders truly believe the ACA is disastrous for the country and are more than willing to sacrifice the concrete interests of their followers to undermine it.”).

6. See, e.g., THOMAS P. MILLER, *WHEN OBAMACARE FAILS: THE PLAYBOOK FOR MARKET-BASED REFORM* 3 (2012) (“The ACA is not just too misguided to succeed. It is too dangerous to maintain and far too flawed to fix on a piecemeal basis.”); Steven Hayward, Op-Ed., *Obamacare Will Be Repealed Well in Advance of the 2014 Elections*, FORBES (Nov. 11, 2013), <http://www.forbes.com/sites/stevenhayward/2013/11/11/obamacare-will-be-repealed-well-in-advance-of-the-2014-elections/> (“Prediction: even if HealthCare.gov is fixed by the end of the month (unlikely), Obamacare is going to be repealed well in advance of next year’s election.”).

critics dissuade all but the most desperate of citizens from enrolling through the new insurance exchanges, they may yet bring about the very collapse of the individual market that they blame on the ACA (much the same way that investors can make short-sale strategies pay off by convincing others of their bearish outlook).⁷

ACA supporters often employ the same strategy in precisely the opposite direction. By emphasizing the positive attributes of the ACA's market reforms, they hope to convince a broad cross section of consumers to purchase through the new insurance exchanges—not simply for their own benefit or to score a political or policy victory—but also to help the reforms succeed by drawing a reasonable risk pool into these newly formed markets.⁸ The new exchanges do not need enormous enrollment to avoid collapse. Even with modest enrollment, they will survive if a reasonable proportion of people who enroll are not already sick.⁹

Both opponents and proponents of the ACA are actively engaged in massive “spin control” efforts, aimed at changing the outcome even before it happens. We see spin control regularly with candidate debates during fiercely fought presidential elections, but this level of information manipulation in the public policy arena is rare during the actual unfolding of a legislative program that has already been enacted. In this distorted environment, it is difficult to distinguish hype from hyperbole or fact from fallacy. Thus, more than ever before, a dispassionate analysis of the law's

7. See Yglesias, *supra* note 5 (noting that boycotting the ACA could undermine the insurance exchanges by eliminating the requisite mix of healthier-than-average enrollees necessary for a successful outcome).

8. See Chelsea B. Sheasley, *Obamacare Blitz: Can US Persuade Young 'Invincibles' to Buy Health Coverage?*, CHRISTIAN SCI. MONITOR (Sept. 3, 2013), <http://www.csmonitor.com/USA/Politics/2013/0903/Obamacare-blitz-Can-US-persuade-young-invincibles-to-buy-health-coverage> (discussing grassroots efforts to convince individuals within multiple age groups to enroll as well as the potential consequence of nonenrollment for the ACA). One dastardly strategy is to leverage mothers' influence over their sons. Sarah Boseley, *Moms the New Focus of Obamacare's 'Young Invincibles' Recruitment Scheme*, GUARDIAN (Nov. 25, 2013), <http://www.theguardian.com/world/2013/nov/25/obamacare-young-invincibles-recruitment-mothers>.

9. See LINDA J. BLUMBERG & JOHN HOLAHAN, THE AFFORDABLE CARE ACT CAN SURVIVE LOW ENROLLMENT AND ADVERSE SELECTION IN THE FIRST YEAR 1 (2013), available at <http://www.urban.org/UploadedPDF/412975-The-Affordable-Care-Act-Can-Survive-Low-Enrollment-and-Adverse-Selection-in-the-First-Year.pdf> (explaining why “low enrollment does not necessarily mean adverse selection”); Larry Levitt, Gary Claxton & Anthony Damico, *The Numbers Behind “Young Invincibles” and the Affordable Care Act*, HENRY J. KAISER FAMILY FOUND. (Dec. 2013), <http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/> (analyzing various enrollment scenarios).

actual effects is needed to inform those with open minds (however few they might be) about how this major piece of market and social engineering is actually performing.

With this goal in mind, this Article assembles and critiques available information about the ACA's actual, rather than projected, performance. The difficulty this undertaking presents is that, with so many components to this law and so many sources of evidence, it is possible to make just about any case one wants, depending on what standards one decides to apply.¹⁰ If the ACA is expected to finally solve all the problems of the U.S. health care system without causing serious dislocations, the law will obviously fall woefully short. Instead, it is more reasonable to gauge the ACA against a balanced view of what it could plausibly be expected to achieve, as written.¹¹ The ACA's drafters did not aim to fix all that is wrong with U.S. health care, but only to make certain major improvements. In a nutshell, those are to increase coverage and preserve a decent range of choice in the private market.¹²

Accordingly, this Article begins with the ACA's core goal of guaranteeing the availability of insurance coverage and then considers the goal of making insurance affordable. The final Part examines some potential unintended consequences. The Article concludes by noting that, although it is too early to determine the ACA's ultimate performance, the variety of approaches to implementation in different states creates a complex but convenient natural experiment that should reveal whether health care access and consumer protections improve or worsen in states that fully embrace the law as compared to states that actively oppose it. That real-world test should prove to be the best evidence of whether the ACA's supporters or detractors are on firmer ground.

10. For a contrasting review of the literature, see, for example, Michael Tanner, *Obamacare: What We Know Now*, POLY ANALYSIS (Cato Inst., Washington, D.C.), Jan. 27, 2014, available at http://object.cato.org/sites/cato.org/files/pubs/pdf/pa745_web_1.pdf.

11. See SHEILA P. BURKE & ELAINE C. KAMARCK, CTR. FOR EFFECTIVE PUB. MGMT. AT BROOKINGS, *THE AFFORDABLE CARE ACT: A USER'S GUIDE TO IMPLEMENTATION 15-24* (2013), available at <http://www.brookings.edu/~media/research/files/papers/2013/10/15%20affordable%20care%20act%20user%20guide%20burke%20kamarck/kamarckburkeaca%20user%20guide101513.pdf> (identifying eight measures to evaluate the ACA's effectiveness).

12. See WASH. POST, *LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL* 68 (2010) (explaining that "for all its scope, the law is a relatively moderate and incremental document—evolutionary, not revolutionary").

II. INSURANCE AVAILABILITY

A. *Universal Insurance*

It is often wrongly claimed that the ACA is designed to achieve universal insurance coverage.¹³ To the contrary, Congress understood that, even if fully effective, the ACA will leave tens of millions of people uninsured.¹⁴ This is so for several reasons. First, the Act does nothing to extend coverage to legal immigrants who have lived in the country fewer than five years or to illegal immigrants.¹⁵

Second, the “individual mandate” exempts people whose insurance premiums remain unaffordable.¹⁶ Third, not everyone eligible for coverage is expected to enroll.¹⁷ The ACA’s ability to achieve universal coverage is further limited by the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*, which ruled that states may opt out of Medicaid’s expansion and that individuals may legally choose to remain uninsured if they are willing to pay the required tax penalty.¹⁸

13. See, e.g., *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2657, 2664–65, 2668–70, 2672 (2012) (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (stating repeatedly that the ACA’s “goal” is to provide “near-universal coverage”); Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL’Y 266, 272 n.30 (2011) (claiming that the ACA was a “push for universal insurance”). Congress itself is a source of confusion on this point. In reciting findings to support federal authority for the ACA, Congress declared that the law “achieves near-universal coverage.” 42 U.S.C. § 18091(2)(D) (2012). In the next two paragraphs, however, the ACA correctly states that its aim is to “significantly reduc[e] the number of the uninsured.” *Id.* § 18091(2)(E)–(F).

14. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>. This understanding is reflected in the fact that, in several provisions, the ACA refers to those who remain uninsured in the context of various programs and provisions designed to help provide care for those uninsured individuals. See, e.g., 42 U.S.C. § 1395ww(r) (using the number of remaining uninsured to calculate each state’s distribution of “disproportionate share hospital” payments); *id.* § 256(a) (ordering the Secretary of Health and Human Services to establish a “3 year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees”).

15. See 42 U.S.C. § 18032(f)(3); MATTHEW BUETTGENS & MARK A. HALL, ROBERT WOOD JOHNSON FOUND., WHO WILL BE UNINSURED AFTER HEALTH INSURANCE REFORM? 5 (2011), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69624 (“Undocumented immigrants are banned from coverage in the health benefit exchanges and are ineligible for Medicaid.”).

16. 26 U.S.C. § 5000A(e)(1), (2) (2012).

17. See BUETTGENS & HALL, *supra* note 15, at 1, 11 tbl.5 (outlining the eligible groups of people expected to remain uninsured after the program is implemented).

18. *Nat’l Fed’n of Indep. Bus.*, 132 S. Ct. at 2608. The latter point downgrades the law’s “minimum essential coverage” requirement from a “mandate” to function more like the “play-or-pay” option that the ACA provides to larger employers, who also may legally

Based on these limitations, the Congressional Budget Office estimates that the ACA will reduce the number of uninsured by about 25 million, leaving 30 million people (or about 11% of the population) uninsured by the end of the decade.¹⁹ Realize, however, that these projections are merely estimates. The failure to achieve them, or the ability to exceed them, speaks more to refinements of the assumptions made to generate the estimates than it does to whether the law is a failure or success, unless the magnitude of shortfall or windfall is great. Thus, within limits, the ACA's success does not depend squarely on how much it actually reduces the number of uninsured people. Even with maximal success, the ACA will never approach 100% coverage. As long as it makes a substantial dent in the number of uninsured, the ACA will have succeeded to some significant extent.

B. Universal Insurability

Rather than achieving actual universal coverage, the ACA's central accomplishment is universal *insurability*. Even if substantial numbers of people remain uninsured, the ACA guarantees everyone the ability to obtain coverage at average community rates.²⁰ It does so by prohibiting insurers from turning anyone down, or charging them more, for health-related reasons.²¹ Also, the ACA requires insurers to cover people's preexisting health conditions, and it allows them to adjust rates for demographics based only on limited and specified factors (such as a three-fold variation based on age, but none based on gender).²²

The effectiveness of these core consumer guarantees can easily be gauged. They took effect simply by legislative fiat, at

choose between offering coverage to workers or paying a prescribed tax. See 26 U.S.C. § 4980H(a).

19. CONG. BUDGET OFFICE, INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT—CBO'S FEBRUARY 2014 BASELINE tbl.2 (2014) [hereinafter CBO'S FEBRUARY 2014 ESTIMATE], available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAables.pdf>.

20. See 42 U.S.C. § 300gg(a)(1) (prohibiting health insurance issuers from charging discriminatory premium rates); KAISER COMM'N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER—KEY FACTS ABOUT HEALTH INSURANCE ON THE EVE OF HEALTH REFORM 19 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-e28093-key-facts-about-health-insurance3.pdf>. These guarantees apply to citizens and immigrants alike. See Esther Yu-Hsi Lee, *A Simple Guide to the Affordable Care Act for Immigrants*, THINK PROGRESS (Oct. 1, 2013), <http://thinkprogress.org/immigration/2013/10/01/2708441/affordable-care-act-immigrant-types-coverage/#>.

21. 42 U.S.C. § 300gg-4(a)–(b).

22. *Id.* §§ 300gg(a)(1), 300gg-3(a).

the stroke of midnight January 1, 2014.²³ Many states amended their laws to conform, but state implementation is not required for the ACA's central insurance reforms to take effect.²⁴ Even states (such as Texas) that forbid state officials from assisting with ACA implementation acknowledge that these core insurability guarantees constitute the law of the land.²⁵ The only way in which these key ACA aims would not be achieved, then, would be if insurers simply violate the law or find ways to circumvent it. However, no such defiance or noncompliance is being reported or observed.²⁶

Although the ACA's core aim of universal insurability is achieved essentially with a "stroke of the pen," other provisions were not so easily implemented. Several have been delayed or abandoned altogether. The most significant part of the ACA to fail so far is the Community Living Assistance Services and Supports Act (CLASS Act).²⁷ It would have created a federally operated insurance program for long-term care, such as extended stays in nursing homes or on-going home care.²⁸ The program was cancelled in 2011 based on federal actuaries' determination that it was not financially sustainable.²⁹ The key features were that the program was to be financed entirely by premiums paid by voluntary enrollees, premiums would be adjusted by income so that poorer people paid less, and, once people had contributed for the requisite length of time (five years), they could not be

23. *Id.*

24. *See Compliance*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html> (last visited Mar. 8, 2014) (explaining how the program will work in relation to states that do not implement its insurance reforms); Katie Keith & Kevin Lucia, The Commonwealth Fund, *Implementing the Affordable Care Act: The State of the States* (Jan. 2014), <http://www.commonwealthfund.org/Publications/Fund-Reports/2014/Jan/Implementing-the-Affordable-Care-Act.aspx> (same).

25. *See* News Release, The Commonwealth Fund, *New Commonwealth Fund State-by-State Analysis: Most States Taking Action to Implement Affordable Care Act's Insurance Reforms; Approached Vary Widely 2* (Jan. 31, 2014), http://www.commonwealthfund.org/~media/Files/News/News%20Releases/2014/State%20of%20the%20States%20release%2013_30_FINAL.pdf (noting that while five states have "declined to play any role in implementing the [ACA]'s reforms," all have allowed the federal government to create a marketplace within their jurisdiction).

26. *See supra* note 5.

27. *See* American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (repealing the CLASS Act); Letter from Kathleen Sebelius, Secretary, U.S. Dep't of Health & Human Servs., to Congress (Oct. 14, 2011) [hereinafter Letter from Kathleen Sebelius], *available at* <http://web.archive.org/web/20111015083531/http://www.hhs.gov/secretary/letter10142011.html> ("I do not see a viable path forward for CLASS implementation at this time.").

28. Pub. L. No. 111-148, 124 Stat. 119, 828 (2010) (codified as amended at 42 U.S.C. § 30011).

29. Letter from Kathleen Sebelius, *supra* note 27.

declined.³⁰ Actuaries could not model a set of premiums and benefits that would attract enough enrollees to be sustainable.³¹ Either premiums would be affordable but benefits too low or benefits would be attractive but premiums too high.³²

C. Exchange Implementation

Other aspects of the ACA have been implemented only after significant effort and some delay. Key to the ACA's aim to make insurance affordable is its establishment of insurance exchanges. Exchanges are not essential for insurability because the insurability provisions apply market-wide—both inside and outside the new exchanges.³³ However, well-functioning exchanges are needed to enable people to shop more easily for coverage and to provide premium subsidies. As readers well know, the biggest difficulty the ACA has faced to date was the disastrous rollout of the federal website for the new insurance exchanges.³⁴

For several weeks at the start of open enrollment, the federal exchange website was virtually dysfunctional due to serious design flaws.³⁵ As of this writing, the major problems affecting the consumer's interface have been greatly reduced and functionality appears to be satisfactory, but additional "back-end" problems remain for how information is transmitted to

30. NAT'L HEALTH POLICY FORUM, THE COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS) ACT: MAJOR LEGISLATIVE PROVISIONS 1–2, 6–7 (2013), available at http://www.nhpf.org/library/the-basics/Basics_CLASSAct_01-03-12.pdf.

31. DEPT OF HEALTH & HUMAN SERVS., A REPORT ON ACTUARIAL, MARKETING, AND LEGAL ANALYSIS OF THE CLASS PROGRAM 44, available at <http://web.archive.org/web/20111014232252/http://aspe.hhs.gov/daltcp/Reports/2011/class/index.pdf> ("While the designated CLASS Plan is operational, solvency or legal problems may prevent the CLASS program from continuing to implement the plan."); Letter from Kathleen Sebelius, *supra* note 27.

32. See James C. Capretta & Brian M. Riedl, *The CLASS Act: Repeal Now, or Face Permanent Taxpayer Bailout Later*, BACKGROUND (Heritage Found., Washington, D.C.), July 26, 2010, at 1, 2, available at http://thf_media.s3.amazonaws.com/2010/pdf/bg2441.pdf (suggesting a mismatch between benefits and premiums).

33. Ann Carrns, *Health Insurance Options Aren't Limited to Government Exchanges*, N.Y. TIMES, Oct. 26, 2013, at B4.

34. See Robert Pear, Sharon LaFraniere & Ian Austen, *From the Start, Signs of Trouble at Health Portal*, N.Y. TIMES, Oct. 13, 2013, at A1 (describing the "serious technical problems" associated with the website); see also Jeffery Young, *Obamacare Website Failure Threatens Health Coverage for Millions of Americans*, HUFFINGTON POST (Oct. 18, 2013), http://www.huffingtonpost.com/2013/10/18/obamacare-train-wreck_n_4118041.html (discussing the urgency with which website administrators were attempting to resolve the website's issues).

35. Young, *supra* note 34 (noting that the website was down for over two weeks and that the "glitches" affecting the website were unacceptable); see also Lizette Alvarez & Jennifer Preston, *Health Care Exchange Is Vastly Improved, Participants Say*, N.Y. TIMES, Dec. 10, 2013, at A19.

insurers.³⁶ Also, the component of the new exchanges that is designed for small employers will not be operational during 2014. Due to various technical problems, the Obama administration delayed implementation of what is known as the Small Business Health Options Program (SHOP) Exchange until 2015 for states that have not created their own exchanges,³⁷ and even the states that have done so have delayed their small employer component somewhat.³⁸ Small employers can still benefit from the ACA's provisions, however, when they purchase coverage directly from insurers.³⁹

Inevitably, the technology problems will be resolved, but critics claim that their initial severity indicates the government's inability to competently administer the ACA for a longer duration.⁴⁰ There are several lines of convincing response.⁴¹ Despite the federal government's initial level of incompetence, many of the ACA exchanges created by state governments functioned quite, or at least acceptably, well from the outset.⁴² This indicates that government competence is not unheard of. Moreover, the similar insurance shopping architecture that the federal government previously developed for choosing private prescription drug coverage under Medicare Part D functions well, despite its initial design problems.⁴³

36. See *Healthcare.gov 'Vastly Improved,' but Back-End Problems Persist*, KAISER HEALTH NEWS (Dec. 10, 2013), <http://www.kaiserhealthnews.org/Daily-Reports/2013/December/10/reform-website-status.aspx> (“[I]t is unclear how many of those who enroll in plans may have had garbled or incomplete information sent to insurers because of continuing back-end problems.”).

37. Robert Pear, *Another Delay for Health Law as Snags Persist*, N.Y. TIMES, Nov. 28, 2013, at A1; Jason Millman, *Small Business Obamacare Online Enrollment Delayed a Year*, POLITICO (Nov. 27, 2013), <http://www.politico.com/story/2013/11/online-shop-enrollment-delayed-by-one-year-100438.html>.

38. See Lisa Stiffler, *Lack of Health-Insurance Options Frustrates Small Businesses*, SEATTLE TIMES, (Dec. 14, 2013), http://seattletimes.com/html/healthcare/2022452537_acasmallbizxml.html (“Maryland and Mississippi are delaying the launch of their business exchanges until spring 2014 . . .”).

39. Millman, *supra* note 37.

40. See, e.g., David Brooks, *The Legitimacy Problem*, N.Y. TIMES, Dec. 24, 2013, at A23; Maggie Fox, *Obamacare Is Here and so Are the Glitches*, NBC NEWS (Oct. 1, 2013), <http://www.nbcnews.com/health/health-care/obamacare-here-so-are-glitches-f8C11299971>.

41. As a largely rhetorical point, it is ironic that bitter critics of the law, who only recently encouraged people to boycott the new exchanges, and who shut down the federal government in an effort to stop the exchanges from opening, now fault the law for being difficult to enroll. One might expect these difficulties to be a point of celebration for those who oppose the reforms this adamantly.

42. See, e.g., Abby Goodnough, *California Exchange Beats All Others in Enrollment*, N.Y. TIMES, Nov. 14, 2013, at A18 (detailing the success of California's exchange).

43. Memorandum to House Energy and Commerce Comm. Democratic Members and Staff, Jan. 16, 2014, available at <http://democrats.energycommerce.house.gov/sites/default/files/documents/Memo-ACA-Medicare-Part-D-Enrollment-2014-1-16.pdf>

Second, it is important to recognize that the private sector does not always implement major information technology systems competently. This is especially so in health care. According to one informal survey of chief information officers at hospitals, most “have been associated with an [information technology] initiative that stumbled out of the gate, and a whopping 86% have felt pressured to forge ahead with a project that was fraught with errors.”⁴⁴ Electronic medical records have been especially problematic. Ask anyone in hospital administration who has switched to an electronic records system how well this has worked and, if they are candid, you are likely to hear tales of woe. Implementing comprehensive electronic records systems has repeatedly caused major disruptions, sometimes bordering on disasters, at sophisticated and well-financed medical institutions across the country,⁴⁵ including my own, the Wake Forest Baptist Medical Center.⁴⁶ “Much anticipated, and sometimes hyped, electronic health record system rollouts cost millions of dollars and often end up causing chaos, frustration, even firings at hospitals across the country.”⁴⁷ “The nearly \$1 billion electronic health record system at Sutter Health in Northern California failed [in August 2013] leaving nurses and clinical staff unable to access any patient information for a full day.”⁴⁸ “Even the

(quoting Rep. John Boehner praising the success of Medicare Part D despite falling well short of the enrollment initially projected); Jack Hoadley, *How Does ACA's First Week Compare to Medicare Part D's?*, GEORGETOWN UNIV. HEALTH POLICY INST. (Oct. 5, 2013), <http://ccf.georgetown.edu/all/how-does-acas-first-week-compare-to-medicare-part-ds/>; Sarah Kliff, *The Last Time the Government Expanded Health Care, It Was Also Kind of a Disaster*, WASH. POST: WONKBLOG (Oct. 11, 2013, 12:27 PM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/10/11/the-last-time-the-government-expanded-health-care-it-was-also-kind-of-a-disaster/>.

44. Kate Gamble, *SnapSurvey: Most CIOs Pressured to Forge Ahead with Flawed Projects*, HEALTH SYSTEM CIO (Nov. 20, 2013), <http://healthsystemcio.com/2013/11/20/snapsurvey-botched-launches-nothing-new-cios/>.

45. For details about numerous examples, see the reports compiled by health information technology expert and Drexel University Adjunct Professor and Consultant in Medical Informatics Scot Silverstein, M.D. Scot M. Silverstein, HEALTH CARE RENEWAL, <http://hcrenewal.blogspot.com/> (last visited Mar. 8, 2014). See generally H.I.T. OR MISS: LESSONS LEARNED FROM HEALTH INFORMATION TECHNOLOGY IMPLEMENTATIONS (Jonathan Leviss et al. eds., 2010).

46. Richard Craver, *Electronic Records Conversion Loss Offset by Investment Gains for Wake Forest Baptist*, WINSTON-SALEM J. (Aug. 30, 2013), http://www.journalnow.com/business/business_news/local/article_8e499690-11b0-11e3-a1d3-001a4bcff6878.html (“The rollout of the Epic electronic health records system contributed to a \$55.1 million operational loss . . .”).

47. Bernie Monegain, *Go-Live Gone Wrong: Are There Lessons to be Had from a Maine Hospital's Rollout Troubles?*, HEALTHCARE IT NEWS (July 31, 2013), <http://www.healthcareitnews.com/news/go-live-gone-wrong>.

48. Erin McCann, *Setback for Sutter After \$1B EHR Crashes: 'No Access to Medication Orders, Patient Allergies and Other Information Puts Patients at Serious Risk,'* HEALTHCARE IT NEWS (Aug. 28, 2013), <http://www.healthcareitnews.com/news/setback-sutter-after-1b-ehr-system%20crashes>.

internationally respected Mayo Clinic, which treats more than a million patients a year, has serious unresolved problems after working for years to get its three major electronic records systems to talk to one another.”⁴⁹

Technical problems can be solved both by the private and the public sectors. The concern, however, is that the delay in doing so for the exchange websites will suppress and skew enrollment seriously enough to cause the entire regulatory and subsidy structure to collapse or to function much more expensively and less effectively than designed.⁵⁰ Older, sicker people are much more highly motivated to work through the website problems in order to gain subsidized coverage that covers preexisting conditions.⁵¹ But, a balanced risk pool requires that a substantial portion of enrollees be younger and healthier.⁵² Insurers’ initial premiums in the exchanges were based on actuarial assumptions about the unknown age and health status mix of enrollees under the new market rules.⁵³ If the actual experience is substantially worse than projected, rates for individual coverage could jump in 2015, or participating insurers could exit the market.⁵⁴ It is too early to know whether, or to what extent, this will happen; some observers see troubling signs, while others remain cautiously optimistic.⁵⁵

49. Milt Freudenheim, *The Ups and Downs of Electronic Medical Records*, N.Y. TIMES, Oct. 9, 2012, at D4.

50. See Young, *supra* note 34 (explaining the long-term impacts of the insurance exchange website failures).

51. Michael D. Shear & Robert Pear, *Older People Lead Sign-Ups for Insurance*, N.Y. TIMES, Jan. 14, 2014, at A1.

52. *Id.*

53. See SARA R. COLLINS, THE COMMONWEALTH FUND, YOUNG ADULT PARTICIPATION IN THE HEALTH INSURANCE MARKETPLACES: JUST HOW IMPORTANT IS IT? 9–10 (2014), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2014/Feb/1732_Collins_young_adult_participation_hlt_ins_marketplaces_v2.pdf.

54. MICHAEL TANNER, CATO INST., BAD MEDICINE: A GUIDE TO THE REAL COSTS AND CONSEQUENCES OF THE NEW HEALTH CARE LAW 9 (2011), available at <http://www.cato.org/sites/cato.org/files/pubs/pdf/BadMedicineWP.pdf>.

55. See COLLINS, *supra* note 53 (stating that even extremely low enrollment by young persons is not likely to lead to market failure); Anna Wilde Mathews, *WellPoint Says New-Customer Rolls Skew Older Under the Health Law*, WALL ST. J., Jan. 30, 2014, at B4 (“Some analysts have projected that insurers could break even or lose money on marketplace plans this year.”). For ongoing insightful analysis with wonderfully revealing graphics, see University of Houston Law Center Professor Seth Chandler’s blog, which “explor[es] the likely implosion of the Affordable Care Act.” Seth Chandler, ACA DEATH SPIRAL, <http://www.acadeathspiral.org/> (last visited Mar. 8, 2014); see also John C. Goodman, *Death Spirals*, NAT’L CTR. FOR POLICY ANALYSIS: JOHN GOODMAN’S HEALTH POLICY BLOG (Oct. 21, 2013), <http://healthblog.npcpa.org/death-spirals/> (speculating that ACA exchanges are in danger of “death spirals”).

III. INSURANCE AFFORDABILITY

A. *Medical Costs*

The “Affordable Care Act” is not aptly named. The ACA is much more about making health *insurance* affordable, rather than medical care itself.⁵⁶ Naturally, underlying health care cost is what drives the cost of insurance, and having insurance makes care more affordable for patients, but the ACA does little to actually reduce the costs of care.⁵⁷ Despite including “essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending,”⁵⁸ there are only a handful of proven cost-containment measures,⁵⁹ and the ACA deploys them in only a tentative and circumscribed manner.⁶⁰ Accordingly, actually reducing the cost of care should not be seen as one of the ACA’s principal objectives. Certainly, if the ACA were to substantially increase the trend in medical inflation, that would be a negative performance measure. Therefore, monitoring medical spending trends is an important component of tracking the ACA’s performance. But caution should be exercised in attributing any slowdowns in medical inflation to the ACA.

Nevertheless, some leading commentators have made just this claim, noting that, following the ACA’s enactment, health care spending has slowed to the historically low rate of just over 1% a year (per capita, adjusted for inflation).⁶¹ Nobel economist Paul

56. See David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FLA. INT’L U. L. REV. 67, 72, 77 (2010) (stating that the ACA will have minimal effects on health care cost inflation); Carolyn O’Hara, *An Obamacare Expert Tells All: What You Need to Know About the Affordable Care Act*, FORBES (Oct. 11, 2013), <http://www.forbes.com/sites/learnvest/2013/10/11/an-obamacare-expert-tells-all-what-you-need-to-know-about-the-affordable-care-act/> (pointing out that the ACA does not control medical costs).

57. See Orentlicher, *supra* note 56, at 72, 77.

58. Letter from Henry J. Aaron, Senior Fellow, The Brookings Inst., et al. to Paul Ryan, Chairman, House Comm. on the Budget & Chris Van Hollen, Representative, U.S. House of Representatives (Jan. 26, 2011), *available at* <http://www.americanprogressaction.org/wpcontent/uploads/issues/2011/01/pdf/budgetcommitteefinal.pdf>.

59. See *id.* (detailing cost-containment options); see also *Options for Controlling the Cost and Increasing the Efficiency of Health Care: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 111th Cong. 2 (2009) (statement of Douglas W. Elmendorf, Director, Congressional Budget Office) (same).

60. See TANNER, *supra* note 54, at 24 (“Most [of the cost-containment provisions in the ACA] are well intentioned but unlikely to have significant impact . . .”); Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 HEALTH MATRIX 75, 78–80, 93–94 (2012).

61. WHITE HOUSE COUNCIL OF ECON. ADVISERS, TRENDS IN HEALTH CARE COST GROWTH AND THE ROLE OF THE AFFORDABLE CARE ACT 3–5 & tbl.1, fig.1 (2013),

Krugman, for instance, suggested recently that the ACA might be a cause of “the slowdown in health costs [that] has been dramatic.”⁶² And Harvard economist David Cutler has opined that “[i]t is increasingly clear that the [medical] cost curve is bending, and the ACA is a significant part of the reason.”⁶³

It is quite plausible that some specific ACA provisions have helped to slow growth in health spending. The ACA cut payments to private “Medicare Advantage” plans, and it penalized hospitals with excessive rates of patients who are readmitted within thirty days of discharge.⁶⁴ However, these provisions account for very little of the cost slowdown.⁶⁵ Other aspects of reduced growth are likely due, primarily, to residual effects of the recession and to other preexisting trends in the health care sector.⁶⁶ Nevertheless, it is encouraging that the ACA appears initially to be having some restraining effects on cost growth, in part because this will help to offset the spending increases that naturally will ensue from increased insurance coverage under the ACA.

B. Insurer Competition

One way the ACA might continue to temper medical care cost increases is by intensifying competition among insurers. Part III.D below discusses how the ACA might affect insurance premiums—which are the most visible aspect of health care costs that consumers face. But also important is the amount of choice that consumers have among competing insurance plans. Despite prophecies that the ACA’s regulations would drive an exodus of insurers from the market,⁶⁷ there has been only a modest reduction so far in the number of insurers with 1,000 or more members in each market segment. In 2012, there were roughly 500 insurers in each market segment nationwide (individual,

available at http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf.

62. Paul Krugman, Op-Ed., *Obamacare’s Secret Success*, N.Y. TIMES, Nov. 29, 2013, at A33.

63. David Cutler, Op-Ed., *The Big Success Story of the Health-Care Law*, WASH. POST, Nov. 10, 2013, at B3.

64. 42 U.S.C. §§ 1395w-23, 1395ww (2012).

65. WHITE HOUSE COUNCIL OF ECON. ADVISERS, *supra* note 61, at 14.

66. See CTR. FOR MEDICARE & MEDICAID SERVS., ANALYSIS OF FACTORS LEADING TO CHANGES IN PROJECTED 2019 NATIONAL HEALTH EXPENDITURE ESTIMATES (2013), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

67. See, e.g., TANNER, *supra* note 54, at 9; Kate Rogers, *Will Americans Really Be Able to Keep Their Current Health Insurance in 2014?*, FOX BUS. (July 3, 2013), <http://www.foxbusiness.com/personal-finance/2013/07/03/health-care-individual-market-california/>.

small group, and large group) with 1,000 or more members, reflecting only a modest decrease of 6%–11% from 2011 in the individual and small group markets, and no decrease in the large group market.

The individual market, which traditionally has had less competition, is also fairly robust in the new insurance exchanges in many, but not all, states. According to one comprehensive analysis, the exchanges in half the states, which cover two-thirds of the uninsured population, have about as many or more competing insurers as existed in those states' non-exchange individual markets prior to the ACA.⁶⁸ Of the 282 different insurers competing in the exchanges across the states in 2014, 80, or 28%, are new to the market.⁶⁹ However, a dozen states have fewer than three insurers on their exchange, and insurers often do not cover the entirety of each state they are in, so that many rural regions have substantially fewer competitors than do urban areas.⁷⁰

C. Provider Competition

As noted above, the ACA has almost no provisions that directly affect the cost of care paid for by private insurance.⁷¹ Its various provider payment reform provisions (that are not merely study commissions or calls for research and demonstration) are aimed almost entirely at Medicare.⁷² Nevertheless, the ACA's insurance market reforms could indirectly affect provider payments by intensifying competition among insurers, who

68. MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, MCKINSEY & CO., EMERGING EXCHANGE DYNAMICS: TEMPORARY TURBULENCE OR SUSTAINABLE MARKET DISRUPTION? 2 (2013); see also OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, DEPT HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE PREMIUMS FOR 2014, at 2 (2013), available at http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/data_sheet_home.Cfm.

69. See MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, MCKINSEY & CO., EXCHANGES GO LIVE: EARLY TRENDS IN EXCHANGE DYNAMICS 2 (2013), available at http://www.mckinsey.com/~media/McKinsey/dotcom/client_service/Healthcare%20System%20and%20Services/PDFs/Exchanges_Go_Live_Early_Trends_in_Exchange_Filings_October_2013_FINAL.ashx.

70. Reed Abelson, Katie Thomas & Jo Craven McGinty, *Health Care Law Fails to Lower Prices for Rural Areas*, N.Y. TIMES, Oct. 24, 2013, at A1 (reporting that 58% of the counties served by the federal exchanges have fewer than three insurers).

71. See *supra* Part III.A.

72. See generally HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT 8 (2013), available at <http://www.kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf> (summarizing provisions of the ACA that make cuts to Medicare provider payments); STEPHEN ZUCKERMAN & JOHN HOLAHAN, URBAN INST. HEALTH POLICY CTR., THE AFFORDABLE CARE ACT ADDRESSES HEALTH CARE COST CONTAINMENT 2 (2012), available at <http://www.urban.org/UploadedPDF/412665-The-Affordable-Care-Act-Addresses-Health-Care-Cost-Containment.pdf> (same).

negotiate with providers.⁷³ Indeed, evidence of pronounced changes in provider competition is already emerging from the initial experience under the new insurance exchanges. Right out of the gate, most leading insurers, and many smaller ones, were able to negotiate deeper provider discounts with narrower provider networks for the insurance products they are offering through the exchanges, compared to the hospital and physician prices and networks they offer to employer groups.⁷⁴ According to one analysis, for instance, one leading national insurer (Anthem Blue Cross) offers in nine states only one-third to one-half the number of specialists in its exchange plans in as it does in its group plans.⁷⁵ Another analysis reports that, in the twenty metropolitan areas studied, two-thirds of exchange networks exclude 30% or more of the areas' larger hospitals.⁷⁶

The large group market does not encourage narrow networks because many employers hesitate to purchase a product that requires workers to change physicians or switch preferred hospitals, and insurers naturally design their commercial networks to meet the needs of their largest clients.⁷⁷ By subsidizing and energizing a distinct market for individual purchasers, the ACA sets the stage for a much different market dynamic—one that potentially rewards an insurer that can offer a lower premium in exchange for restricting choice to providers that offer the best value.⁷⁸ This could push markets closer to the

73. See Robert Pear, *Lower Premiums to Come at Cost of Fewer Choices*, N.Y. TIMES, Sept. 23, 2013, at A1 (finding that insurers have cut fees paid to doctors in efforts to provide competitive premiums on health insurance exchanges).

74. See *id.* (reporting limited provider networks and reduced provider payments as common among plans offered on exchanges).

75. See *Challenges of the Affordable Care Act: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 113th Cong. 5 (2013) (statement of Scott Gottlieb, Resident Fellow, American Enterprise Institute), available at <http://www.aei.org/speech/health/challenges-of-the-affordable-care-act/> (describing that the number of providers in the exchange as compared to the number of providers in a group plan ranges from 35%–56%, dependent on the medical specialty area).

76. MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, MCKINSEY & CO., HOSPITAL NETWORKS: CONFIGURATIONS ON THE EXCHANGES AND THEIR IMPACT ON PREMIUMS 2–3 (2013), available at http://www.mckinsey.com/~media/mckinsey/dotcom/client_service/healthcare%20systems%20and%20services/pdfs/hospital_networks_configurations_on_the_exchanges_and_their_impact_on_premiums.ashx.

77. See Pear, *supra* note 73 (finding that plans offered on exchanges are modified from plans offered to employers); David Dranove & Craig Garthwaite, *In Defense of Narrow Networks*, THE HEALTH CARE BLOG (Oct. 22, 2013), <http://thehealthcareblog.com/blog/2013/10/22/in-defense-of-narrow-networks/> (“Employers rarely offer narrow networks because it is very hard to find a single network that appeals to all (or even a large fraction) of their employees . . .”).

78. See JOHN HOLAHAN ET AL., URBAN INST., CROSS-CUTTING ISSUES: INSURER PARTICIPATION AND COMPETITION IN HEALTH INSURANCE EXCHANGES: EARLY INDICATIONS FROM SELECTED STATES 3, 8 (2013), available at <http://www.rwjf.org/content/dam/farm/>

“managed competition” ideal of choosing insurance from among distinct and competing networks of providers, based both on price and good information about the quality of care.⁷⁹

The narrower networks that insurers have initially formed for the ACA marketplace are not necessarily based, however, on the full embodiment of value-based purchasing.⁸⁰ Most networks simply use standard fee-for-service discounting.⁸¹ However, the establishment of a distinct market segment that supports narrower provider networks could lead to networks that have truly integrated delivery systems and that employ the full panoply of outcome-based quality measures and performance-based provider payment systems.⁸²

D. Insurance Premiums

Among the various issues being publicly debated regarding the ACA’s effects, the most contentious has been how it affects insurance premiums. Critics shout that younger, healthier people are facing “rate shock,” with some seeing increases of 300% or more.⁸³ Defenders point to the effect of the premium tax subsidies available through the new exchanges, which greatly reduce the “sticker price” of insurance⁸⁴—actually bringing it to

reports/issue_briefs/2013/rwjf406939 (“A major determinant of how insurer competition will affect premiums is the ability of insurers . . . to create narrower networks that . . . allow them to offer an attractive product in the market.”).

79. ZUCKERMAN & HOLAHAN, *supra* note 72, at 1.

80. See Pear, *supra* note 73 (relating concerns that the narrow provider networks offered in plans on the health insurance exchanges may result in high costs to consumers who need to visit a specialist or receive treatment at an out-of-network facility).

81. See HOLAHAN ET AL., *supra* note 78, at 8–9 (finding that plans offered on health insurance exchanges include providers with whom the insurer has successfully negotiated with for lower reimbursement rates).

82. See AMERICA’S HEALTH INS. PLANS, HIGH PERFORMANCE PROVIDER NETWORKS 4 (2013), available at http://www.ahipcoverage.com/wp-content/uploads/2013/12/Issue-Brief_High-Performance-Networks.pdf (observing that insurers can leverage small networks and performance metrics to demand higher performance and quality of care from providers); Pear, *supra* note 73 (reporting that insurers will have a higher degree of control over the quality of care provided within narrow networks).

83. MAJORITY STAFF OF H. COMM. ON ENERGY & COMMERCE, THE LOOMING PREMIUM RATE SHOCK 1, 4–5 (2013), available at http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/insurancepremiums/Final_Report.pdf; Robert Pear, *Health Care Law Will Raise Some Premiums, Study Says*, N.Y. TIMES, Mar. 29, 2013, at A15.

84. HENRY J. KAISER FAMILY FOUND., QUANTIFYING TAX CREDITS FOR PEOPLE NOW BUYING INSURANCE ON THEIR OWN 1–2 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8469-quantifying-tax-credits-for-people-now-buying-insurance-on-their-own.pdf>; Editorial, *Dawn of a Revolution in Health Care*, N.Y. TIMES, Sept. 29, 2013, at SR10.

zero in some common scenarios.⁸⁵ Both sides of this debate are, to some extent, talking past each other. They each cite formulaic aspects of the new premium rating and subsidy rules, with critics emphasizing the negative aspects and defenders emphasizing the positives.⁸⁶ Community rating, by definition, creates winners and losers: younger healthier people pay more than their actuarial cost so that premiums are reduced to affordable levels for older, sicker people. As Justice Ginsburg noted in her *National Federation of Independent Business v. Sebelius* opinion, even if some people end up paying in more than they receive, “they have little to complain about, for that is how insurance works.”⁸⁷

Rather than focusing on the distributional extremes of the ACA’s rating and subsidy formulae—more or less as exercises in mathematical tautologies—the debate over insurance premiums should focus instead on market-wide averages or other measures that capture a more complete social picture. Doing so, the initial evidence appears to be favorable for the ACA’s impact on insurance premiums. First, the nonsubsidized “sticker” prices of insurance premiums on the new exchanges are generally in line with, or sometimes even lower than, the rates that insurers are offering to employer groups.⁸⁸ These prices are substantially lower than initially anticipated.⁸⁹ This favorable pricing appears to result from the sharply price-competitive dynamic that the exchanges foster, where people are expected to pick from among

85. See MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, *supra* note 69, at 7 (“Across the U.S., 6 to 7 million people may be eligible for a zero-net-premium bronze plan and ~1 million may be eligible for a zero-net-premium silver plan.”).

86. Compare *Dawn of a Revolution in Health Care*, *supra* note 84 (applying premium subsidy formulas to conclude that the ACA will make health care coverage affordable to millions of Americans), with Avik Roy, *Double Down: Obamacare Will Increase Avg. Individual-Market Insurance Premiums By 99% For Men, 62% For Women*, APOTHECARY, FORBES BLOG (Sept. 25, 2013, 4:00 AM), <http://www.forbes.com/sites/theapothecary/2013/09/25/double-down-obamacare-will-increase-avg-individual-market-insurance-premiums-by-99-for-men-62-for-women/> (arguing that the application of premium subsidies will not be sufficient to offset increases in insurance premiums for many consumers).

87. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2620 (2012) (Ginsburg, J., concurring).

88. LAURA SKOPEC & RICHARD KRONICK, OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, DEPT’ OF HEALTH & HUMAN SERVS., MARKET COMPETITION WORKS: PROPOSED SILVER PREMIUMS IN THE 2014 INDIVIDUAL AND SMALL GROUP MARKETS ARE NEARLY 20% LOWER THAN EXPECTED 4 fig.1, 5 fig.2, 7 tbl.1 (2013), available at http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.pdf; PRICEWATERHOUSE COOPERS, *Health Insurance Premiums: Comparing ACA Exchange Rates to the Employer-Based Market*, <http://www.healthreformgps.org/wp-content/uploads/pwc-1-31.pdf>.

89. SKOPEC & KRONICK, *supra* note 88, at 2; see also OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, *supra* note 68, at 2–3.

the lower cost options.⁹⁰ Favorable pricing is also aided by the ACA's risk-spreading mechanisms known as reinsurance and risk corridors, which help to shelter insurers from some of the initial pent-up demand for services by newly enrolling patients with medical needs.⁹¹

In addition to moderate sticker prices, consumers benefit from the ACA's premium subsidies, which vary substantially according to income and family composition.⁹² Therefore, characterizing the impact of these subsidies is not straightforward. However, it is relevant to note that, because subsidies are available to people who earn four times the poverty level, the majority of people who purchase individual insurance will be eligible for some subsidy.⁹³ Among those who qualify, the subsidy will be about \$5,000 per family,⁹⁴ including those who currently have no insurance, or about \$2,500 per family among people who are currently insured.⁹⁵

Even taking these subsidies into account, one leading critic estimates that individual-market premiums are 41% higher in the first year (2014) than before.⁹⁶ This analysis is flawed, however, by the arbitrary assumption that people who were denied coverage based on health problems would have to pay only three times more for coverage if insurers are required to cover them.⁹⁷ This clearly is inadequate to reflect the expected costs for people with preexisting conditions.⁹⁸

90. See Kelly Kennedy, *Study: Employees Often Pick Lower-Cost Health Plans*, USA TODAY (July 9, 2013), <http://www.usatoday.com/story/news/politics/2013/07/09/consumers-choose-cheaper-insurance/2499957/>.

91. 42 U.S.C. § 18061 (2012) (providing for a reinsurance program to make payments to health insurance issuers "that cover high risk individuals in the individual market"); Mark A. Hall, *The Three Types of Reinsurance Created by Federal Health Reform*, 29 HEALTH AFF. 1168, 1168, 1170–71 (2010).

92. 26 U.S.C. § 36B (2012); see also OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, *supra* note 68, at 1.

93. 26 U.S.C. § 36B; see also GARY CLAXTON ET AL., HENRY J. KAISER FAMILY FOUND., STATE-BY-STATE ESTIMATES OF THE NUMBER OF PEOPLE ELIGIBLE FOR PREMIUM TAX CREDITS UNDER THE AFFORDABLE CARE ACT 1 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8509-state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits.pdf>.

94. CBO'S FEBRUARY 2014 ESTIMATE, *supra* note 19, at tbl.2.

95. HENRY J. KAISER FAMILY FOUND., *supra* note 84, at 3.

96. Avik Roy, *49-State Analysis: Obamacare to Increase Individual-Market Premiums by Average of 41%*, APOTHECARY, FORBES BLOG (Nov. 4, 2013, 5:00 AM), <http://www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly/>; *Obamacare: Know Your Rates*, MANHATTAN INST. FOR POLICY RESEARCH, <http://www.manhattan-institute.org/knowyourrates/about.htm> (last visited Mar. 8, 2014).

97. *Obamacare: Know Your Rates*, *supra* note 96.

98. See JULIE A. SCHOENMAN & NANCY CHOCKLEY, NAT'L INST. HEALTH CARE MGMT. FOUND., THE CONCENTRATION OF HEALTH CARE SPENDING 3 fig.2 (2012), available

Another complication in sorting through the competing claims about rate increases is that rates for 2014 cannot be compared easily with earlier rates on an apples-to-apples basis because the benefits covered by insurance are changing. Naturally, critics blame the ACA for requiring insurers to offer richer benefits than what people previously chose to purchase, even though the ACA's mandated benefits are based in large part on the most popular plans that small employers were choosing to purchase.⁹⁹ Regardless, it has to be conceded that insurance with greater coverage has a higher value and thus merits a higher price. Therefore, a proper analysis of changes in insurance rates would also adjust for these differences in coverage value.

Comprehensive data is not yet available to permit this type of full actuarial analysis for insurance rates in 2014. It is possible, however, to report on more apples-to-apples rate increases for prior years based on insurers' rate filings. Although the federal government does not regulate health insurance rates, its proactive policy of greatly increased transparency has produced an important new source of insight into core health policy questions. Since September 2011, the Department of Health and Human Services, under authority from the ACA, has required health insurers in the individual and small group markets to explain in detail the bases for rate increases of 10% or more in their nongrandfathered products and has made these explanations publicly available in a consumer-friendly format.¹⁰⁰

Analysis of these filings for rate increases that were to take effect during the year July 2012–June 2013 revealed that these larger rate increases covered only about 5%–10% of the

at http://www.nihcm.org/images/stories/DataBrief3_Final.pdf (reporting national data that shows health care expenses in the top half of the population are *thirty-three times* greater than expenses in the bottom half, and per capita expenses in the top 10% of the population are over 100 times more than in the bottom half). Consider, for instance, that these same analysts argue that the same three-fold rate difference is seriously inadequate to reflect the average costs to be expected based merely on age differences. Roy, *supra* note 96.

99. See, e.g., Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Healthcare Reform*, 58 UCLA L. REV. 221, 236–37 (2010); Edmund F. Haislmaier, *Web Memo No. 3110: Obamacare and Insurance Benefit Mandates: Raising Premiums and Reducing Patient Choice*, BACKGROUND (Heritage Found., Washington, D.C.), Jan. 20, 2011, at 1, 2–4, available at http://thf_media.s3.amazonaws.com/2011/pdf/wm3110.pdf.

100. HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: QUANTIFYING THE EFFECTS OF HEALTH INSURANCE RATE REVIEW 2 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8376.pdf>; *2012 Annual Rate Review Report: Rate Review Saves Estimated \$1 Billion for Consumers*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 11, 2012), <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html>.

individual and small group markets nationally.¹⁰¹ Medical costs were the main drivers of these increases, based both on the increased use of medical services and increased unit prices.¹⁰² Increasing administrative overhead and profits were a much smaller factor and were much less present in the individual market.¹⁰³ Although insurers in about half of these filings attributed a portion of their rate increase to the ACA's new taxes and benefit mandates, those that quantified this impact allocated only about 1% of their increased rates to ACA-related factors in the year prior to the law's main provisions taking effect.¹⁰⁴

E. Medical Loss Ratios

Another measure of how well markets perform under the ACA is insurers' efficiency in selling coverage and administering claims. Insurers' medical loss ratio (MLR) is a key financial measure of their efficiency in maintaining low overhead.¹⁰⁵ The ratio reflects what portion of premium dollars a health insurer uses to pay for medical care or for health care quality improvement, as opposed to profits, administrative costs, or sales expenses.¹⁰⁶

One of the ACA's most visible consumer protections is its regulation of MLRs. The ACA sets minimum MLRs for insurers to reduce overhead and thus the ultimate cost of insurance to consumers and the government. Starting January 1, 2011, insurers offering comprehensive major medical policies are required to maintain an MLR of at least 80% in the individual and small-group markets and at least 85% in the large-group market.¹⁰⁷ Insurers that pay out less than these percentages on medical care and quality improvement must rebate the difference to their subscribers.¹⁰⁸ This rule can benefit consumers in two ways: through the value of rebates they actually receive and by inducing insurers to become more efficient in order to avoid having to pay rebates.

101. Michael J. McCue & Mark A. Hall, The Commonwealth Fund, *What's Behind Health Insurance Rate Increases?* 2, 6 (Dec. 2013), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1721_McCue_whats_behind_hlt_ins_rate_increases_ib.pdf.

102. *Id.* at 4.

103. *Id.* at 4–5 & exhibit 4.

104. *Id.* at 5–6.

105. Michael J. McCue & Mark A. Hall, The Commonwealth Fund, *Insurers' Responses to Regulation of Medical Loss Ratios* 1 (Dec. 2012), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/1634_McCue_insurers_responses_MLR_regulation_ib.pdf.

106. *Id.*

107. 42 U.S.C. § 300gg-18(b)(1)(A) (2012).

108. *Id.*

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Table 1 presents the first year of experience under the MLR rule. Overall, insurers that fell below the MLR minimums in 2011 paid out \$1.1 billion in rebates. In addition, the insurance industry as a whole benefitted consumers by reducing its overhead by \$350 million from 2010 to 2011. Reduced overhead took the form of both lower administrative costs (such as reduced sales commissions) and somewhat lower profits. The overhead reductions and rebates produced a combined consumer benefit of \$1.45 billion in 2011. In 2012, these consumer benefits increased to almost \$2 billion.¹⁰⁹

Table 1: Change in Overhead and Rebate Amounts Owed, 2011¹¹⁰

	Individual	Small Group	Large Group	Total
Change in Overhead 2010–2011[†]	\$(560) million	\$36 million	\$174 million	\$(350) million
Rebate Owed	\$(394) million	\$(321) million	\$(386) million	\$(1.10) billion
Total	\$(954) million	\$(285) million	\$(212) million	\$(1.45) billion

[†] Change in overhead equals the sum of the change in administrative costs and profit.

IV. UNINTENDED CONSEQUENCES

A. *Employment Effects*

In addition to gauging whether the ACA achieves its stated goals, sober assessment also requires measuring whether it causes any unintended consequences. One of the ACA's possible negative effects is to restrain employment. On the other hand, the ACA could well spur employment.¹¹¹

109. Michael J. McCue & Mark A. Hall, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year Two* (forthcoming 2014) (manuscript at 2–4) (on file with the *Houston Law Review*).

110. McCue & Hall, *supra* note 105, at 5 exhibit 2. This Table has been slightly modified from its original form.

111. See JOHN HOLAHAN & BOWEN GARRETT, URBAN INST., HOW WILL THE AFFORDABLE CARE ACT AFFECT JOBS? 1 (2011), available at <http://www.urban.org/UploadedPDF/412319-Affordable-Care-Act-Affect-Jobs.pdf> (predicting that labor in the health care sector will be in higher demand, “including increasing use of medical equipment, new technologies and pharmaceuticals”). See generally *The Impact of the Health Care Law on the Economy, Employers, and the Workforce: Hearing Before the*

Negative effects on employment might occur for two different reasons. First, requiring larger employers to offer coverage or pay a tax might slow or deter job growth.¹¹² Second, because the ACA's "employer mandate" is keyed to a firm's full-time employees, people fear that it will cause employers to convert more positions to part time, reducing workers' ability to earn a living wage.¹¹³ Benefits to employment could arise in a couple of ways. First, if some employers can reduce their health benefits costs by sending workers to the new exchanges for subsidized individual coverage, these employers might be able to afford to hire more workers.¹¹⁴ Second, prohibiting insurers from rejecting unhealthy people or refusing to cover their preexisting conditions can free people to pursue more entrepreneurial ventures, knowing that they need not worry that they might not be able to find coverage on their own.¹¹⁵

It is still too early to gauge with any reliability which of these various possibilities might emerge and, if so, to what degree. One unpublished study reports that the ACA's provision extending coverage to adult dependents through age twenty-five substantially increased self-employment among people ages nineteen to twenty-five.¹¹⁶ Most recently, however, the

Comm. on Educ. & the Workforce, 112th Cong. (2011) (statement of George Miller, Senior Democratic Member, Comm. on Educ. & the Workforce).

112. *The Impact of the Health Care Law on the Economy, Employers, and the Workforce: Hearing Before the Comm. on Educ. & the Workforce*, *supra* note 111, at 8–9, 26 (statements of Paul Howard, Senior Fellow, Manhattan Institute, and Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation).

113. See 26 U.S.C. § 4980H(a) (2012) (imposing penalties on large employers for failing to offer health coverage to full-time employees); *The Impact of the Health Care Law on the Economy, Employers, and the Workforce: Hearing Before the Comm. on Educ. & the Workforce*, *supra* note 111, at 18 (statement of Gail Johnson, President/CEO, Rainbow Station, Inc.) ("[The ACA] establishes an employer mandate to provide health insurance coverage to employees. If employers do not purchase coverage, they will be subject to a penalty of \$2,000 per full-time worker." (emphasis added)); Annie Lowrey & John Harwood, *Despite Criticisms, Health Care Law's Impact on Jobs Is Still Unclear*, N.Y. TIMES, Oct. 3, 2013, at A18 (discussing employers' concerns that the ACA "may affect their hiring practices" and force them to reduce employees' hours).

114. See HOLAHAN & GARRETT, *supra* note 111, at 2 (positing that small firms will "have lower costs of labor and should be more willing to expand employment" because they can purchase coverage for employees in Small Business Health Options Program (SHOP) exchanges).

115. See LINDA J. BLUMBERG, SABRINA CORLETTE & KEVIN LUCIA, THE AFFORDABLE CARE ACT: IMPROVING INCENTIVES FOR ENTREPRENEURSHIP AND SELF-EMPLOYMENT 3–4 (2013), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406367 (estimating that the ACA will increase the number of self-employed people by about 1.5 million, which is more than a 10% increase).

116. James Bailey, Health Insurance and the Supply of Entrepreneurs: New Evidence from the Affordable Care Act's Dependent Coverage Mandate (Mar. 7, 2013) (unpublished manuscript), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2230099.

Congressional Budget Office (CBO) estimated that, by 2024, the ACA will lead to a reduction in work hours amounting to 2.5 million full-time equivalent jobs,¹¹⁷ but it also said that this “reduction in work is expected to come almost entirely from a decline in the amount of labor that workers choose to supply in response to the changes in their incentives,” rather than because employers eliminate jobs.¹¹⁸

However one might interpret the CBO’s *projection*, claims that the ACA is *already* causing employers to eliminate large numbers of jobs are clearly overstated. Such effects on a large scale are not plausible yet, simply because the employer mandate has been delayed until 2015.¹¹⁹ It is possible that some employers are making adjustments now, in anticipation of the law, but any such direct effects of the ACA are most likely swamped by more general factors in the broader economy.¹²⁰ Part-time positions shot up during the recession for purely economic reasons, but their portion of the workforce is starting to decline, not increase.¹²¹ It is possible that anticipation of the ACA has slowed this decline, but there is no strong evidence that this speculative possibility is the case. Instead, analysts project that, when the ACA’s employer provisions take effect, they are likely to increase part-time positions by only a percentage point or two.¹²²

117. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK 2014–2024, at 127 app. C (2014) <http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf>.

118. *Frequently Asked Questions About CBO’s Estimates of the Labor Market Effects of the Affordable Care Act*, CONG. BUDGET OFF. (Feb. 10, 2014), <http://www.cbo.gov/publication/45096>.

119. See Lowrey & Harwood, *supra* note 113 (“[M]ajor provisions of the [ACA] have yet to take effect, meaning many of the assertions about how the law is slashing hours or encouraging part-time employment are not backed by statistical evidence . . .”).

120. See WILLIAM J. DENNIS JR., NFIB RESEARCH FOUND., SMALL BUSINESS’S INTRODUCTION TO THE AFFORDABLE CARE ACT: PART 1, at 20–21 & tbl.7 (2013), available at <http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/ppaca/nfib-aca-study-2013.pdf> (concluding, based on a survey of 921 small employers, that “[p]lans to reduce employee hours . . . seem strongly tied to profitability rather than [to the] ACA”).

121. Lowrey & Harwood, *supra* note 113; Jared Bernstein & Paul Van de Water, Op-Ed., *Obamacare Isn’t Destroying Jobs*, POLITICO (Aug. 6, 2013), <http://www.politico.com/story/2013/08/obamacare-isnt-destroying-jobs-95239.html>.

122. See Dave Graham-Squire & Ken Jacobs, *Which Workers Are Most at Risk of Reduced Work Hours Under the Affordable Care Act?*, UC BERKELEY LABOR CTR. 2 (2013), available at http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf (citing examples of the Hawaii and Massachusetts health care laws, both of which yielded negligible percentage changes in the number of part-time employees); Lisa Dubay, Sharon K. Long & Emily Lawton, *Will Health Reform Lead to Job Loss? Evidence from Massachusetts Says No.*, URBAN INST. 8–9 & tbl.3 (2012), <http://www.urban.org/UploadedPDF/412582-Will-Health-Reform-Lead-to-Job-Loss-Evidence-from-Massachusetts-Says-No.pdf> (“The evidence from Massachusetts would suggest that national health reform does not imply job loss and stymied economic growth.”); Rob Valletta & Leila Bengali, *What’s Behind the Increase in Part-Time Work?*,

B. Insurer Effects

ACA critics argue that its excessive regulation will cripple or destroy portions of the insurance industry.¹²³ Commenting on “[t]he economic chaos that is likely to follow the disruption of private insurance health-care markets,” Richard Epstein apocalyptically predicted that:

[t]he inexorable squeeze between the constricted revenue sources allowable that insurers get under the Reid bill [which became the ACA] and the extensive and uncertain new legal obligations it imposes is likely to result in a massive cash-flow crunch that will drive the firms in the individual and small-group health insurance markets into speedy bankruptcy.¹²⁴

Very much to the contrary, the insurance market continues to thrive, due in part to the hundreds of billions of dollars of additional revenues it will receive from the ACA over the next decade.¹²⁵

Anticipating this economic boon, health insurers’ stock prices outpaced by more than two-fold the market’s overall substantial increase during the two months prior to the Senate’s initial approval on Christmas Eve 2009.¹²⁶ Increasing stock prices reflect investor optimism about health insurers’

FRBSF ECON. LETTER 4 (Aug. 26, 2013), available at <http://www.frbsf.org/economic-research/publications/economic-letter/2013/august/part-time-work-employment-increase-recession/el2013-24.pdf>.

123. See Anna Bernasek, *The Dawn Of Obamacare Hasn't Hurt Insurers' Stocks*, N.Y. TIMES, Oct. 27, 2013, at BU7 (stating that some analysts believe that health insurance companies will see low profits as the new regulations take effect); Richard A. Epstein, Op-Ed., *Harry Reid Turns Insurance into a Public Utility: The Health Bill Creates a Massive Cash Crunch and Then Bankruptcies for Many Insurers*, WALL ST. J., <http://online.wsj.com/news/articles/SB10001424052748704304504574610040924143158> (last updated Dec. 22, 2009) (asserting that health insurance companies will be forced out of the market because the ACA “run[s] afoul of the constitutional guarantee that all regulated industries have to a reasonable, risk-adjusted, rate of return on their invested capital”); Bill Frezza, Op-Ed., *Obama to Health Insurance Companies: Merry Christmas. Now, Drop Dead.*, FORBES (Dec. 23, 2013), <http://www.forbes.com/sites/billfrezza/2013/12/23/obama-to-health-insurance-companies-merry-christmas-now-drop-dead/> (proclaiming that recent changes made by the Department of Health and Human Services to the ACA could be “the last nail in the coffin of commercial health insurance”).

124. Epstein, *supra* note 123.

125. Bernasek, *supra* note 123 (discussing how insurance companies’ stock prices and average annual earnings per share are on the rise); Pradip Sigdyal & Giovanni Moreano, *Surging Health Care Index Sets Another Record*, CNBC (Apr. 2, 2013), www.cnbc.com/id/100538665.

126. See Jack Hough, *3 Stocks Soaring on Health-Care Bill*, WALL ST. J: SMART MONEY (Dec. 22, 2009), <http://web.archive.org/web/20101018015007/http://www.smartmoney.com/investing/stocks/3-stocks-soaring-on-healthcare-bill/> (showing that from October 2009 to December 2009, the U.S. stock market gained 8% and the stocks of Aetna, Cigna, and WellPoint gained 31%, 29%, and 28%, respectively).

business prospects under the new law throughout the four years following its enactment, even as its various details have become more crystalized through regulation and staged implementation.¹²⁷ Morgan Stanley maintained a Healthcare Payor Index “designed to measure the performance of companies involved in the business of managing the health care dollar, including HMOs (health maintenance organizations) and PBMs (pharmaceutical benefit managers).”¹²⁸ On the eve of the law’s enactment, in November 2009, the index was below 1,400.¹²⁹ By March 2011, when the indexing ceased, it had reached over 2,000—more than a 40% increase;¹³⁰ this increase was roughly twice that of the general stock market over the same period.¹³¹

Health insurers’ stocks have continued to show excellent performance since then. According to one recent account,

Over the last 12 months, shares of the top five publicly traded health insurance companies—Aetna, WellPoint, UnitedHealth Group, Humana and Cigna—have increased by an average of 32 percent, while the Standard & Poor’s 500-stock index has risen by just 24 percent. . . . [O]ne probable explanation for the outperformance by the group . . . is the growing expectation that payments from new customers required to buy insurance under the Affordable Care Act will offset costs from new regulations. Health insurance

127. Bernasek, *supra* note 123 (explaining that the ACA has not been “much of a hindrance” to the health care industry); Hough, *supra* note 126 (indicating that “[t]he stock market’s collective view” is that health insurance companies will profit following the passage of the ACA); Sigdyal & Moreano, *supra* note 125 (inferring that the stock market remains positive about the prospects of the health care industry as the health care sector rose 17% from January 2013 to April 2013).

128. *Morgan Stanley Health Care Payors—HMO*, NYSE EURONEXT http://www.amex.com/othProd/prodInf/OpPiIndMain.jsp?Product_Symbol=HMO (last visited Mar. 8, 2014).

129. *Morgan Stanley Healthcare Payors Index*, GOOGLE FIN., http://www.google.com/finance?q=INDEXNYSEGIS%3AHMO&ei=Q-u-Uoj_NoSwqgHwSA (last updated Oct. 18, 2013).

130. *Morgan Stanley Health Care Payors—HMO*, *supra* note 128. For data since March 2011, see the S&P 500 Managed Health Care index, which shows as of December 5, 2013, about a 50% increase in the past year, and about a 100% increase in the past three years. See *S&P 500 Managed Health Care (Sub Ind)*, FIN. TIMES, <http://markets.ft.com/research/Markets/Tearsheets/Summary?s=SP500-35102030:IOM> (last visited Mar. 8, 2014) (reporting a 46.6% increase over 2012); Ed Yardeni & Joe Abbott, *S&P 500 Industry Briefing: Managed Health Care*, YARDENI RESEARCH, INC. 1 fig.1 (Mar. 7, 2014), <http://www.yardeni.com/pub/if-ghm.pdf> (showing a 100% increase in the S&P 500 Managed Health Care Index from 2011 to 2013).

131. Data can be found at *S&P 500 Index*, GOOGLE FIN., http://www.google.com/finance?q=INDEXSP%3A.INX&ei=7w6_UtDrC6SGsgesrWE (last visited Mar. 8, 2014), which shows the S&P 500 Index figures from November 2009 through March 2011.

companies themselves haven't exactly sounded an alarm about the Affordable Care Act's arrival. . . . And most health insurers are forecasting earnings growth after the health care law is fully in effect. . . . If such projections are correct, someday we may look back and wonder what all the fuss was about.¹³²

Professor Epstein's prediction of partial industry collapse with "near mathematical certainty"¹³³ could not have been proven more wrong.

V. CONCLUSION

The ACA's major provisions did not take initial effect until January 1, 2014,¹³⁴ and it will require at least two years to see how these new rules and subsidies sort themselves out in the market. Even though it is too early to tell how well or badly the ACA will work to increase insurance availability and affordability, it is possible to see now that critics' worst prophecies are wrong so far, but also that supporters' best hopes have not yet been achieved. The ACA does not aim to, and so cannot be expected to, substantially reduce the actual cost of health care.¹³⁵ However, it has achieved the major accomplishment of making insurance universally available by outlawing insurers' practices that excluded, or charged substantially more for, unhealthy people and preexisting conditions.¹³⁶ The ACA has also put into place a set of subsidies that makes private insurance much more affordable for tens of millions of people.¹³⁷

The initial performance of the new insurance exchanges has been mixed. Poor website design seriously compromised initial enrollment in the early months, and this may have spillover effects for insurers' rates and participation in the second year (2015). However, in the first year of open enrollment, most states have seen a good degree of choice and an impressive level of price competitiveness among

132. Bernasek, *supra* note 123; *see also* Sigdya & Moreano, *supra* note 125 ("So far this year, the health [insurance] group is up 17 percent, outperforming not only the broader market, but [the] rest of the nine major S&P 500 sectors.").

133. Richard A. Epstein, *Impermissible Ratemaking in Health-Insurance Reform: Why the Reid Bill Is Unconstitutional*, POINT OF LAW 21, 23 (Dec. 18, 2009), <http://www.pointoflaw.com/columns/archives/2009/12/impermissible-ratemaking-in-he.php>.

134. 42 U.S.C. § 18001(a) (2012).

135. *See supra* note 56–57 and accompanying text.

136. 42 U.S.C. §§ 300gg(a)(1), 300gg-3(a).

137. 26 U.S.C. § 36B(a).

participating insurers.¹³⁸ And, other than requiring several million people (which is a small percentage overall) to give up their existing nonqualifying coverage, the ACA so far has caused little dislocation.¹³⁹ In particular, not many employers so far have dropped coverage, and predictions that insurers would quickly leave the market in droves and suffer devastating losses have proven false.¹⁴⁰ Instead, many insurers have embraced this new market opportunity both to build enrollment and to develop new approaches to managing the costs of care, which could well have spillover benefits for the broader private insurance market.¹⁴¹

Implementation of the ACA has been uneven across the states, however. Most startling, half the states, for largely political reasons, have refused to expand Medicaid even though the federal government would pay for almost all of the costs.¹⁴² This leaves a major gap in the ACA's coverage scheme because people whose income falls below the poverty level receive no subsidies on the exchanges.¹⁴³ Moreover, many of these same

138. See *supra* Part III.B.

139. See Jeffrey Dorfman, Op-Ed., *The High Costs Of Obamacare Hit Home For The Middle Class*, FORBES (Oct. 31, 2013), <http://www.forbes.com/sites/jeffreydorfman/2013/10/31/the-high-costs-of-obamacare-hit-home-for-the-middle-class/> (explaining why the major parts of the ACA “are a wash for most people”); *How Does the Affordable Care Act Affect People Who Buy Health Insurance in the Individual Market?*, FAMILIES USA (Dec. 20, 2013), <http://www.familiesusa.org/ACA-individual-market/> (calculating that, at most, only 0.6% of the nonelderly population will be required to give up their existing insurance for something more expensive).

140. Compare Epstein, *supra* note 123 (positing that health insurance companies would be driven out of the market following the passage of the ACA), and Frezza, *supra* note 123 (referring to health insurers as “the walking dead”), with PRICEWATERHOUSECOOPERS, *THE MASSACHUSETTS EXPERIENCE: EMPLOYER-SPONSORED HEALTH INSURANCE POST REFORM 1–2* (2013), available at <http://www.pwc.com/us/en/health-industries/health-research-institute/publications/assets/hri-whitepaper-article.pdf> (reporting that Massachusetts employer-based insurance has increased by around 1% since its healthcare law was enacted compared to a 5.7% decline nationwide), and *Health Care Reform Heightens Employers' Strategic Plans for Health Care Benefits*, TOWERS WATSON (Aug. 21, 2013), <http://www.towerswatson.com/en-US/Press/2013/08/Health-Care-Reform-Heightens-Employers-Strategic-Plans-for-Health-Care-Benefits> (finding that 98% of employers plan to retain health insurance plans through 2014 and 2015).

141. Bruce Japsen, *Despite Glitches, Obamacare Profit Windfall to Insurers Well Underway*, FORBES (Oct. 26, 2013), <http://www.forbes.com/sites/brucejapsen/2013/10/26/despite-glitches-obamacare-profit-windfall-to-insurers-well-underway/> (indicating that health insurers are forecasting increased revenues and profits as the ACA is implemented).

142. Sabrina Tavernise & Robert Gebeloff, *Millions of Poor Are Left Uncovered by Health Law*, N.Y. TIMES, Oct. 3, 2013, at A1 (“The 26 states that have rejected the Medicaid expansion are home to about half of the country's population, but about 68 percent of poor, uninsured blacks and single mothers.”).

143. *Id.* (providing “Catch-22” examples of people who could not qualify for subsidies under the ACA because they were below the poverty line, and also could not qualify for Medicaid because of their state's current form of Medicaid).

balking states are taking an openly obstructionist stance to the ACA's private insurance reforms by refusing to establish their own exchanges and by barring state officials from assisting with outreach, enrollment, and enforcement.¹⁴⁴

As unfortunate as this politically motivated obstructionism might be, it does have the researcher's advantage of creating a natural experiment that can test the ACA's effectiveness. If the ACA works across the board despite the unprecedented level of resistance in many places, then it will be shown to be a resounding success. If it fails or falls seriously short even in the most supportive states, then opponents will be shown to be presciently correct. More likely, however, is that the ACA's aims of increased coverage and affordability will meet with variable success across the states. If that pattern relates directly to the pattern of states' acceptance and resistance, we will then have a strong base of evidence that the ACA debate is, in part, a clash of competing self-fulfilling prophecies. The law may work if we actually want it to, but concerted efforts to undermine the law in some parts of the country may, themselves, bring about the very failure, or at least the shortfall, that pessimists foretell.

144. Lizette Alvarez & Robert Pear, *Several States Undercutting Health Care Enrollment*, N.Y. TIMES, Sept. 18, 2013, at A11 (giving examples of states that "are complicating enrollment efforts and limiting information about the new program"); Richard Cauchi, *State Legislation and Other Actions Challenging Certain Health Reforms*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx> (last updated Feb. 28, 2014) ("[Sixteen] states currently have statutory or state constitutional language providing that state government will not implement or enforce mandates requiring the purchase of insurance by individuals or payments by employers." (emphasis omitted)); *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, 2014*, HENRY J. KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/#> (last updated Dec. 11, 2013) (showing the states that have rejected Medicaid expansion as well as those that have opted for a "federally-facilitated marketplace").