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**Health Insurance, Risk, and Responsibility after the
Patient Protection and Affordable Care Act**

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HEALTH INSURANCE, RISK, AND RESPONSIBILITY AFTER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

TOM BAKER*

INTRODUCTION

With the passage of the Patient Protection and Affordable Care Act, health insurance in the United States is on track to become a form of social insurance. While all insurance is social – so that “the losse lighteth rather easily upon many, than heavilie upon fewe”¹ – to be considered social insurance in the traditional sense, the insurance must be compulsory and easily available, and the price must bear some relation to the ability to pay.²

Parts of the U.S. health insurance system already meet those requirements, most significantly Medicare (for the elderly and formerly working disabled), Medicaid (for certain categories of the poor, including all children in low income families), and workers compensation (for employment-related illness and injury).³ U.S. income tax and employment law strongly encourage the provision of general health benefits through employment, making employment-based health insurance a *de facto* obligation for most large employers and many small employers.⁴ But the legal choice to offer health insurance remains that of the employer, and individuals’ only health insurance obligations are to pay Medicare taxes and to participate in the financing of Medicaid through the payment of their ordinary state and federal taxes. The Affordable Care Act will make large employers’ obligation *de jure* starting in 2014, and it will extend individuals’ legal

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¹ An Acte conc[er]ning matters of Assurances, amongste Marchantes, 1601, 43 Eliz., ch. 12 (Eng.).

² Isaac Max Rubinow, *Social Insurance* at 3 (1916) (“social insurance is the policy of organized society to furnish that protection to one part of the population which some other part may need less or if needing is able to purchase voluntarily through private insurance”).

³ See *infra* at __

⁴ Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, 25 HEALTH AFFAIRS 1538 (2006).

obligation so that they must obtain health insurance for their entire lifetime, not just for old age or the event of total disability.

The Affordable Care Act embodies a social contract of healthcare solidarity through private ownership, markets, choice, and individual responsibility. While some might regard this contract as the unnatural union of opposites – solidarity on the one hand and markets, choice, and individual responsibility on the other – those familiar with insurance history will recognize in the Act an effort to realize the dream of America’s early insurance evangelists: “society united on the basis of mutual insurance.”⁵ Public ownership and pure, tax-based financing are technically easier and almost certainly cheaper routes to healthcare solidarity, but they come at a cost to the status quo that Congress was not prepared to pay.

This essay explores the contours of the solidarity and individual responsibility embodied in the Act. Part one explains the four main health care financing and risk distribution institutions reflected in the Act – Medicare, Medicaid, the individual and small employer market, and the large group market – with an emphasis on how the Act changes those institutions and how they are financed. Part two focuses on the distribution of risk and responsibility within and among those institutions. I will argue, first, that the new healthcare social contract extends the fair share approach to health care financing while rejecting the actuarial fairness vision of what constitutes a fair share and, second, that the Act points toward the recognition of a new responsibility to be as healthy as you can. This new responsibility reflects the influence of health economics and health ethics, and it is part of the embrace of risk first described in the insurance as governance literature.⁶ Part three identifies challenges to achieving the solidarity through individual responsibility envisioned in the Act – most significantly what I will call “risk classification by design” – and explores the regulatory tools that the Act gives the states, the new Exchanges, and the Department of Health and Human Services to address these challenges.

1. DISTRIBUTING HEALTH CARE RISK: THE FOUR LEGGED STOOL

Since the 1970s there have been three relatively well functioning health care risk distribution mechanisms in the U.S. and one poorly functioning one. The three better functioning

⁵ See D.R. Jacques, *Society on the Basis of Mutual Life Insurance*, 16 Hunt’s Merchant Magazine & Commercial Review 152 (1849).

⁶ See Tom Baker & Jonathan Simon eds., *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* (2002).

mechanisms are Medicare, Medicaid, and the large group market. The poorly functioning mechanism is the individual and small group market. We can think of U.S. health care risk distribution as a wobbly stool. Some people spill things while sitting on it. Others fall off.

Consistent with this metaphor, the Affordable Care Act makes only incremental changes to Medicare, Medicaid, and the large group insurance market (though the Medicaid change is historic in terms of U.S. social welfare policy). The Affordable Care Act dramatically reforms the individual and small group insurance market with the aspiration of stabilizing the four legged stool. Understanding these changes is a necessary first step to understanding the new healthcare social contract. I will begin with Medicare and Medicaid, which are the easy parts to explain at the general level. I will then turn to the individual and small group market, finishing with the large group market.

A. Medicare.

The Affordable Care Act made no fundamental changes to Medicare, which is the health insurance component of the Social Security program. Accordingly, health insurance for the eligible disabled (those who paid, or were dependents of someone who paid, Social Security taxes for 40 quarters before becoming totally disabled) and seniors (who paid, or were married to someone who paid, Social Security taxes for 40 quarters) will continue to consist of four parts:

- Part A, which covers inpatient care, hospice care, and some home health services and is financed entirely by a flat percentage tax on wages paid over the lifetime;
- Part B, which covers other medically necessary or preventive services and is funded in part by a flat percentage tax on wages paid over the lifetime (75%) and in part by premiums paid when enrolled (25%) that are based in part on income and are otherwise uniform regardless of age, health status, or anything else;
- Part C, Medicare Advantage, which is a private sector alternative to Parts A and B that allows individuals to obtain their health care benefits, typically including prescription drug benefits, from the healthcare financing companies active in the large group market explained below and is funded in much the same way as parts A, B, and D.

- Part D, which covers prescription drugs and is funded by premiums that vary according to the type of plan but are otherwise uniform regardless of age, health status, or anything else.⁷

The Affordable Care Act changes Medicare financing and risk distribution in three main ways:

- Increasing the progressivity of Medicare financing by raising the wage tax on higher income taxpayers,⁸ adding an income-based component to Part D premiums,⁹ and freezing the thresholds for income-based increments to Part B premiums;¹⁰
- Changing the cost-sharing formula for Part D so that individuals will gradually pay a smaller percentage of the costs of medication at the point of sale (meaning that a greater percentage of the costs will be paid in the form of Part D premiums);¹¹ and
- Reducing federal payments to Medicare Advantage plans,¹² providing bonuses for quality ratings,¹³ and obligating these plans to maintain a medical loss ratio of at least 85%.¹⁴

⁷ See Medicare.gov – The Official U.S. Government Site for Medicare, <http://www.medicare.gov/default.aspx?AspxAutoDetectCookieSupport=1> (with links explaining parts A, B, C, and D).

⁸ The payroll tax of high income taxpayers will be increased starting from 2013. High income taxpayers are those whose wages or self-employment income exceeds \$200,000 for individuals or \$250,000 for married couples filed jointly. The payroll tax increases by 0.9% from 1.45% to 2.35% on wages, Compilation of Patient Protection and Affordable Care Act [PPACA], Pub. L. No. 111–148 and Pub. L. No. 111–148 § 9015(a) (2010) (amending the Internal Revenue Code [IRC] of 1968 §3101(b)); and from 2.3% to 3.8% on self-employment income, PPACA §9015(b) (amending IRC §140 (b)).

⁹ Part D premium subsidies for high-income beneficiaries will be reduced beginning in 2011. If the modified adjusted gross income (MAGI) of beneficiaries exceeds \$85,000 for individuals and \$170,000 for couples, the monthly amount of the premiums shall be increased by the monthly adjustment amount. The Commissioner of Social Security is delegated to carry out and disclose necessary income-related increases in the base beneficiary premium. PPACA §3308 (a) (1) (amending the Social Security Act [SSA] §1860D-13(a)(7)), SSA §1839(i) (2).

¹⁰ The Act freezes the threshold for income-related Medicare Part B premiums for 2011 through 2019. PPACA §3402 (amending SSA §1839(I)(6)).

¹¹ See Health Care and Education Reconciliation Act [HCERA] §1101 (replacing PPACA § 3315), “Closing the Medicare Prescription Drug ‘Donut Hole’”, at 931 et. seq. In addition, the Act phases down the coinsurance rate into 25% by 2020:

- For brand-name drugs, the Act mandates a Medicare gap coverage discount program by not later than January 1, 2011, which requires manufacturers to provide 50% discount on the negotiated price. PPACA § 3301 (b) (amending SSA § 1860D-14A (a), (g)(4)(A)). This is in addition to federal subsidies providing 25% of the cost by 2020. PPACA § 3301(b)(3)(C) (amending SSA § 1860D–2(b)(D)(ii)).
- For generic drugs, provides federal subsidies of 75% of the cost by 2020, PPACA § 3301(b)(3)(C) (amending SSA § 1860D–2(b)(C)).
- Provides a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010, PPACA § 3301(a) (amending SSA § 1860D–42(c)(1)).

In addition, the Act expands coverage for preventive health services and eliminates cost sharing for services designated as cost effective by the U.S. Preventive Services Task Force. As I will explain in Part Two, this new coverage, if extended along the lines of the parallel aspects of the insurance market reforms in the Act, has the potential to represent a significant change in Medicare's distribution of risk and responsibility.¹⁵

B. Medicaid.

In form, the Act changed Medicaid only incrementally, but these changes are very significant in historical terms. The Act explicitly recognizes, for the first time on a national basis, an entitlement to healthcare for all of the poor – including able-bodied, working age individuals – that will be financed through general tax revenues, abandoning the concept of the deserving poor that has been one of the main features of U.S. social welfare policy, including access to health care.¹⁶ Starting in 2014 all lawful residents of the U.S. with family incomes of less than 133% of the federal

¹² According to the Medicare Payment Advisory Committee, private MA plans on average are paid an estimated 13% more per beneficiary than what are paid per beneficiary in traditional Medicare plans. See Medical News Today, *Efforts to Reduce Payments to Medicare Advantage Plans Expected from Obama Administration*, <http://www.medicalnewstoday.com/articles/130859.php>, (Nov. 26, 2008). To deal with the problem of overpayment, the Act calls for substantial changes to the calculation formula. All counties or similar jurisdictions are ranked in order of their average FFS spending, regardless of their territory or populations. The federal payments (MA benchmarks) will be an applicable percentage of the county's average FFS spending, with higher payments (the MA benchmark as 115% of FFS rates) for areas with low FFS spending and lower payments (the MA benchmark as 95% of FFS rates) for areas with high FFS spending. PPACA § 1102(b) (amending SSA § 1853(n)(1)-(2)). Compared to the prior law (whose benchmarks was in the range of 100 to 140%), the new formula generally reduces benchmarks. The new formula will be phased in during the next two to six years and fully phased in 2017. HCERA § 1102(b) (amending SSA § 1853(n)(3)).

¹³ Beginning in 2010, the MA benchmarks will be increased if the plans receive four or more stars, based on the current 5-star quality rating system; qualifying plans in qualifying areas receive double bonuses. HCERA § 1102(C) (amending SSA § 1853(o)). Beginning in 2010, the MA benchmarks will be increased if the plans receive four or more stars, based on the current 5-star quality rating system; qualifying plans in qualifying areas receive double bonuses. HCERA § 1102(C) (amending SSA § 1853(o)).

¹⁴ HCERA § 1103 (amending SSA § 1857(e)(4)). Beginning in 2014, MA plans which fail to have the minimum medical loss ratio shall remit partial payments to the Secretary. The Secretary shall suspend plan enrollment for three years if the medical loss ratio is less than 85% for 2 consecutive years, and terminate the plan contract if the medical loss ratio is less than 85% for five consecutive years. *Id.*

¹⁵ The Act increases Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates, including preventive services recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual. PPACA § 10406 (amending SSA § 1833(a)(1)(T), (W), (X)). (This section is inserted into PPACA § 4104 in the Compilation of Patient Protection and Affordable Care Act, Public Law 111-148 and Public Law 111-148, 111th Cong. at 482.) In addition, the Act provides for coverage for an “annual wellness visit.” PPACA § 4103 (amending § 1861(s)(2) of the Social Security Act, 42 U.S.C. 1395x(s)(2)). PPACA § 4003, 42 U.S.C. § 300u–11, establishes the United States Preventive Services Task Force.

¹⁶ See, e.g., Frances F. Piven & Richard A. Cloward, *Regulating the Poor: The Functions of Public Welfare* (1993).

poverty index will be entitled to Medicaid.¹⁷ Before the Act, Medicaid was available on a national basis only to pregnant women, children, parents of dependent children, and the elderly and disabled, and individuals in these categories had to meet state-determined income ceilings that varied by category, with a national floor for some categories: 100% of the index for the elderly and disabled and for children aged 7-19, and 133% of the index for pregnant women and children under six.

After the Act, states remain free to expand Medicaid coverage beyond the new national floor and, thus, categorical differences may persist at the state level.¹⁸ But the new incentive for states to establish “Basic Health Plans” for individuals with incomes in the range of 133-200% of the poverty index,¹⁹ together with the economies of scale potentially available from combining Medicaid and Basic Health Plans, creates the possibility for a nearly uniform national entitlement to free health care for individuals in families with incomes up to 200% of the poverty index. Almost all of the new Medicaid costs will be borne by the federal government and paid for out of general revenues.²⁰ States that had previously expanded coverage to individuals that are newly eligible nationally will receive new federal funds on a phased in basis so that they will receive the same percentage of assistance as other states by 2019.²¹

¹⁷ PPACA § 2001(a)(1)(C) (2010) (Amending §1902(a)(1)(C) of the Social Security Act “by inserting after subclause (VII) the following: (VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k)”) (codified as amended at 42 U.S.C. 1396a).

¹⁸ PPACA § 2001(e) (2010) (Amending §1902 of the Social Security Act) (codified as amended at 42 U.S.C. § 1396a).

¹⁹ PPACA § 1331 (2010) (Detailing the guidelines for the “Basic Health Plans” that states can establish to provide health insurance coverage for those individuals with incomes ranging from 133-200% of the Federal Poverty Line) (codified at 42 U.S.C. 18051).

²⁰ PPACA § 2001(a)(3)(B) (2010) (amending the Social Security Act “by adding at the end the following new subsection: “(y) Increased FMAP For Medical Assistance For Newly Eligible Mandatory Individuals.— “(1) Amount Of Increase.—[Replaced by section 1201(1)(B) of HCERA] Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to— “(A) 100 percent for calendar quarters in 2014, 2015, and 2016; “(B) 95 percent for calendar quarters in 2017; “(C) 94 percent for calendar quarters in 2018; “(D) 93 percent for calendar quarters in 2019; and “(E) 90 percent for calendar quarters in 2020 and each year thereafter.”) (codified as amended at 42 U.S.C. 1396a).

²¹ PPACA § 2001(a)(3)(B) (2010) (providing that states receive increased matching funding at the rates of “(A) 100 percent for calendar quarters in 2014, 2015, and 2016; (B) 95 percent for calendar quarters in 2017; (C) 94 percent for calendar quarters in 2018; (D) 93 percent for calendar quarters in 2019; and (E) 90 percent for calendar quarters in 2020 and each year thereafter.”).

C. The individual and small group market.

The Affordable Care Act makes the most dramatic changes to the individual and small group insurance market, aiming to create:

- a single health insurance pool in each state,²²
- populated by all lawful residents in the state who do not have health benefits through a government program or a large employer, and
- serviced by health insurance plans that provide all essential healthcare benefits and compete on the basis of cost and quality, with
- guaranteed access and identical premiums for all, subject to a few narrowly tailored exceptions that do not include health status.

The practical challenges to achieving this goal are addressed in part three. Here I explain only how the market is supposed to work, in order to identify the explicit choices about the distribution of healthcare risk and responsibility embodied in the Act.

For present purposes, the key elements of the individual and small group market reforms are the following:

- The mandates;
- The subsidy;
- Minimum coverage requirements;
- Open enrollment and guaranteed renewal;
- Limits on individual risk-based pricing;
- Risk adjustments; and
- Health exchanges.

The paragraphs that follow briefly explain each of these elements in order to set the stage for the risk and responsibility analysis.

²² See PPACA § 1312 (2010). Initially, the Act creates two separate pools in each state, the individual pool and the small employer pool, but states are permitted to combine the pools, a result that is most consistent with the solidarity objectives of the Act and that, I predict, will be administratively easier and less costly in the long run. *Id.*

The mandates. The Act obligates all lawful citizens obtain “minimum essential coverage”²³ and it obligates all large employers (100 employees or greater) to provide minimum essential coverage to their employees, commencing in 2014.²⁴ The structure of these mandates makes obtaining coverage through the individual and small group market the residual health care financing mechanism for people who do not qualify for a government health benefit program (Medicare, Medicaid, and Veterans benefits) or work for a large employer. The individual mandate is an important part of the solidarity equation because it requires everyone to be in the health insurance risk pool, addressing the adverse selection problem that would follow from other provisions of the Act, described shortly, that make it possible for high risk people to enter the health insurance pool.²⁵

The subsidies. The individual mandate obligates individuals to obtain a health plan. The subsidies encourage them to obtain the plan and reduce the likelihood that they will qualify for the hardship exceptions just mentioned. Beginning in 2014, people with incomes up to 400% of the federal poverty level (FPL) will be eligible for financial assistance to help them pay for coverage through the state health insurance exchanges. Those with incomes under 133% FPL will be covered under the newly-expanded Medicaid program. Those with incomes up to 400% FPL will qualify for tax credits to reduce their premiums. They will also qualify for limited cost-sharing under their plans to ensure they pay less out of pocket. Both the tax credits and reduction in cost-sharing will apply on a sliding scale based on income, and similarly will be structured to coordinate with the plan actuarial categories.²⁶ The subsidies will be funded by general federal revenues, and, thus represent a major ability-to-pay component of the new health care social contract.

²³ PPACA § 1501(b) (2010) (“Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter: “Chapter 48—Maintenance Of Minimum Essential Coverage. . . . Sec. 5000a. . . . (A) Requirement To Maintain Minimum Essential Coverage. An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.”)

²⁴ PPACA § 1304(b)(1) (2010) (defining “large employer” under the Act to be those with 101 employees or more); § 1513(a) (2010) (penalizing “large employers” who do not provide “minimum essential coverage”). The fact that the “minimum essential coverage” definition for large employers is almost content-free is a challenge to the solidarity goal that I will address in part 3.

²⁵ See TAN__, *infra*.

²⁶ PPACA § 2001(a)(1)(C) (2010) (amending the Social Security Act to cover individuals with income up to 133% FPL under Medicaid); § 1401(b)(2) (2010) (providing premium assistance tax credits on a sliding scale for taxpayers with income up to 400% FPL); § 1402(c)(1)(A) (limiting cost-sharing for individuals in qualified health plans by reducing the out-of-pocket limit for households up to 400% of FPL); § 1402(c)(1)(B) (coordinating reductions with actuarial value limits of bronze through platinum plans).

Minimum essential coverage requirements. The minimum essential coverage requirements set minimum contract quality standards on the health plans that may be offered in the individual and small group market beginning in 2014. There are three main aspects to these standards. First, the plan must cover “essential health benefits,” a package of benefits to be defined by the Secretary of Health and Human Services.²⁷ Second, the plan must limit annual cost sharing (e.g. deductibles and co-insurance) to the amount authorized as the ceiling on a Health Savings Account.²⁸ In subsequent years, in the case of self-only coverage, the limitation will be indexed to the annual limit on HSA’s, and for any other plan, the limit on cost sharing will be double that amount.²⁹ Third, the plan must meet one of four “actuarial value” requirements, which vary by level of coverage (bronze, silver, gold and platinum) and which set a percentage ceiling on the aggregate cost-sharing of all the individuals in the plan.³⁰ For example, a Silver level plan cannot impose aggregate cost sharing of more than 30% of the total cost of covered benefits on the participants in the plan.³¹ In addition, the state-based Exchanges appear to have discretion to add additional requirements based on their authority to determine whether “making available [a] health plan through the Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates.”³²

These minimum contract quality standards are designed to ensure that everyone actually receives adequate health care benefits when they fulfill their responsibility to insure. In addition,

²⁷ PPACA § 1302(a), (b) (2010) (defining the essential health benefits package, including terms defined by DHHS).

²⁸ See PPACA § 1302(a)(2) & (c)(1)(A),(B)(i),(ii)/

²⁹ *Id.*

³⁰ PPACA § 1302(a)(3) (establishing that plans must conform to the bronze through platinum levels of coverage); §1302(c) (limiting cost-sharing under the plans); § 1401(c)(1)(B) (2010) (coordinating plans with actuarial levels and limiting cost sharing measures to certain percentages based on those levels).

³¹ PPACA § 1302(d)(1)(B) (2010) (defining a silver level plan as one that covers 70% of policy holder’s costs, or “benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.”).

³² PPACA § 1311 (e) :

(e) CERTIFICATION.—

(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines are inappropriate or too costly.

The Act also contains requirements regarding transparency and quality improvement that are to be enforced by the Exchanges. § 1311 (e), (g), (h). States that require plans to provide coverage for healthcare services that go beyond the essential benefits must pay for the cost of those additional services. [need cite]

by reducing the range of variation among plans, the minimum standards reduce the room for what I call “risk classification by design”: the creation of separate risk pools as individuals’ self select into different health care products according to their self-assessed health risk status (what economists refer to as “separating equilibria”).³³ Risk classification by design is one the most important challenges to the solidarity equation that I will address in part 3.

Open enrollment and guaranteed renewal. The open enrollment³⁴ and guaranteed renewal requirements³⁵ mean that all health insurance plans in the individual and small group market must accept everyone who chooses to apply for or renew health insurance. These requirements eliminate the traditional authority of health insurance companies to choose whom they will insure (an authority that insurance companies have had no realistic choice to exercise in any way other than to exclude from the health insurance pool those people who most need to be in the pool).³⁶ It is important to note that making it too easy for high risk people to join the insurance pool actually poses a challenge to the solidarity equation, by creating the possibility that people will violate the mandate unless and until they really need serious health treatment. This is yet another challenge that I will address in Part 3.

Limits on individual risk-based pricing. In the traditional, actuarial approach to private market insurance, insurance is understood as a series of bi-lateral contracts between insurance companies and their policyholders, and those contracts are understood as wagers, the odds of which (and therefore the price) should be set according to the likelihood that the policyholder will “win” by making a claim.³⁷ If people have the choice whether to buy insurance or not, and if insurance companies have the authority to decide on an individual basis how much to charge for their products, then an insurance company that fails to set prices on this basis will not last long. The result is that those people who most need to be in the pool cannot afford to join the pool, however, because their premiums will be too high.³⁸ Accordingly, achieving health care solidarity

³³ See generally, Alma Cohen & Peter Siegelman, *Testing for Adverse Selection in Insurance Markets*, 77 J. RISK & INS. 39 (2010).

³⁴ PPACA § 1201 (2010) (amending the Public Health Service Act to include § 2702, requiring that every health insurance issuer accept all applicants, but allowing such issuers to limit that to certain “open enrollment” periods.)

³⁵ PPACA § 1201 (2010) (amending the Public Health Service Act to include § 2703(a), “Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.”)

³⁶ See Tom Baker, *Containing the Promise of Insurance*, 9 CONN. INS. L. J. 371 (2003). See also Deborah Stone, *Struggle for the Soul of Health Insurance*, 18 J. OF HEALTH, POLITICS, POLICY & L. 287 (1993).

³⁷ Baker, *Insurance, Risk and the Social Construction of Responsibility*, in Baker & Simon, *supra* note __

³⁸ See Stone, *The Struggle for the Soul*, *supra* note __ at 308 (1993) (“the logic and methods of actuarial fairness mean denying insurance to those who most need care”).

through the private market requires limiting the authority of insurers to decide on an individual basis how much to charge for their products.

The Act allows health plans in the individual and small group market to vary their prices on the basis of only four factors: whether the applicant is an individual or family, the geographic region in which the applicant lives, age, and tobacco use.³⁹ For the latter two factors, there are limits on the pricing differentials, 3:1 for age-based pricing differentials and 1.5:1 for tobacco use pricing differentials, meaning that the price for the oldest group in the pool may not be more than three times the price for the youngest group and the price for the heaviest tobacco users may not be more than one and a half times the price for of comparable non-users.⁴⁰ In addition, the Act permits the sale of high deductible policies to people under the age of thirty, and, presumably, these policies will constitute a separate risk pool.⁴¹ (These policies represent an example of risk classification by design explicitly permitted in the Act.) Finally, the Act authorizes wellness programs for small employer plans that may provide substantial rebates or other benefits to participants (up to 30% of the total premium, including the employer share, potentially increasing to 50%).⁴² The wellness programs have the potential to lead to *de facto* differential prices based on participation in the programs, but the programs may not be “a subterfuge for discriminating based on a health status factor.”⁴³ From a risk and responsibility perspective, these pricing factors and the wellness programs are among the most interesting aspects of the Act, as discussed shortly.

Risk adjustments. Risk adjustments are financial transfers among health plans based on the aggregate risk of the individuals that choose to participate in each plan.⁴⁴ Plans that end up with a disproportionately high risk membership are supposed to receive risk adjustment payments from plans that end up with a disproportionately low risk membership so that the price that individuals

³⁹ PPACA § 1201 (2010) (amending the Public Health Service Act to forbid discriminating price on the basis of any characteristic other than age, family status, rating area, or tobacco use.)

⁴⁰ PPACA § 1201 (2010) (amending the Public Health Service Act to include § 2701, specifying that discrimination can be based on “age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c))” and “tobacco use, except that such rate shall not vary by more than 1.5 to 1.”)

⁴¹ PPACA § 1302 (e)(2)(A) (2010) (defining eligibility for certain catastrophic coverage plans as extending to those under the age of 30.) Tricky issue. See “single risk pool” provision. Also risk adjustment provisions

⁴² Compilation of Patient Protection and Affordable Care Act, Public Law 111–148 and Public Law 111–148, 111th Cong. § 1201 (2010)(amending the Public Health Service Act to include § 2705 (j)(3)(A), which authorizes wellness plans and describes the cost-offsetting incentives available for certain qualifying programs.)

⁴³ PPACA § 1201 (amending the Public Health Service Act to include § 2705 (j)(3)(B) (warning against misuse but not establishing a criteria for how states will evaluate whether wellness programs amount to such subterfuge.)

⁴⁴ PPACA § 1343 (a)(1) (2010) (creating state based risk adjustment mechanism for plans in the individual and small group market). For a recent empirical study of the importance of risk adjustment to redressing classification by design, see Karen Eggleston & Anupa Bir, *Measuring Selection Incentives in Managed Care: Evidence from the Massachusetts State Employee Insurance Program*, 76 J. RISK AND INS. 159 (2009).

pay for their insurance does not depend on their health risk due to risk classification by design or other sorting mechanisms that correlate with risk.⁴⁵

The exchanges. The exchanges are the marketplace through which individuals and small employers will purchase health care plans. Among other responsibilities, the exchanges are charged with making sure that the plans listed on the exchange comply with statutory requirements⁴⁶ They also likely to be asked to administer the risk adjustments.⁴⁷ Important, open questions about the exchanges include how active exchanges should be in helping consumers make choices and whether states should exercise the option of allowing the federal government to create and operate the exchanges.

In summary, the changes to the individual and small group market appear to be designed to make that market function as if all of the individuals who buy insurance in each exchange were the members of a very large single employment group with many choices for health benefits, analogous in many ways to the Federal Employee Health Program.⁴⁸ One very important difference is that purchasers of individual coverage on the Exchange will pay the full price themselves, using after tax dollars (subject to the subsidies). As with “cafeteria plans” in the large group market, there is a potential for risk classification by design. Indeed, because of the very large number of options available on the exchange, some degree of risk classification by design seems inescapable, notwithstanding the risk adjustments and other regulatory tools that I will discuss in Part 3.

D. The large group market

The Act makes few changes to the large group market, in recognition of the belief that this market has been functioning acceptably well to provide access to health care for most people

⁴⁵ PPACA § 1343 (a)(2) (2010)

⁴⁶ 42 U.S.C. § 13031 (exchange responsibilities).

⁴⁷ The Act directs the states to administer the risk adjustment process. 42 U.S.C. § 18063 (directing states to assess risk adjustments). I predict that the states will assign that task to the exchanges for efficiency reasons, though it is possible that the task will be carried out by the state insurance regulator (almost certainly in close cooperation with the exchange).

⁴⁸ Extensive information about the FEHP can be found at the website maintained by the U.S. Office of Management and Budget, <http://www.opm.gov/insure/health/>. See also Alain C. Enthoven, *Effective Management of Competition in the FEHBP*, 8 HEALTH AFFAIRS 33 (2010); Stuart M. Butler & Robert Moffite, *The HEHBP as a Model for a New Medicare Program*, 14 Health Affairs 47 (1995); Harry P. Cain II, *Moving Medicare to the FEHBP Model or How to Make an Elephant Fly*, 18 HEALTH AFFAIRS 25 (1999)

working for large organizations.⁴⁹ The large group market is and will remain lightly regulated by the Department of Labor under the ERISA and HIPPA statutes.⁵⁰ The main change introduced by the Act is that large employers (defined as an entity with more than 100 employees) must provide “minimum essential coverage” to their employees starting in 2014.⁵¹

For large employers that already provide health care benefits (most already do) the new mandate will not impose much in the way of new obligations because – perhaps surprisingly – the Act exempts the large group market from the “essential health benefit” requirements that will apply in the individual and small group market.⁵² Large group market plans do have to meet the same annual cost-sharing limits as health plans in the small group market,⁵³ however, meaning that the out of pocket expenses of employees for covered health care expenses cannot exceed the maximum amount allowed for Health Savings Accounts⁵⁴ and no more than \$4000 of this cost sharing may be in the form of a deductible.⁵⁵ In addition, large group market plans will have to comply with some Affordable Care Act mandates such as coverage for preventive services,⁵⁶ dependent coverage,⁵⁷ wellness programs,⁵⁸ nondiscrimination on the basis of health status,⁵⁹ and reporting.⁶⁰

The Act does regulate the content of large group market plans indirectly. If an employer’s plans are of such low quality that employees start to buy individual health plans on the Exchanges,

⁴⁹ Monahan & Schwarcz at 14-23; President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), *available at* <http://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care>.

⁵⁰ See Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?* VIRGINIA LAW REVIEW (forthcoming Mar. 2011), Minnesota Legal Studies Research Paper No. 10-37 (July 30, 2010), *available at* SSRN: <http://ssrn.com/abstract=1651308>, at 14-22 (summarizing regulation pre- and post-PPACA).

⁵¹ PPACA § 1513 (2010) (amending Chapter 43 of the Internal Revenue Code of 1986 to add a new section 4980H penalizing large employers that fail to offer full time employees the option to enroll in “minimum essential coverage”). See also PPACA § 1411(e)(4)(B)(iii) & f(2)(A) (procedure for notifying employer that employee is eligible for subsidies because the employer is not providing minimum essential coverage and for employer appeal of such determination)).

⁵² 42 USC § 2707 (a) (making the essential benefits applicable only to “[a] health insurance issuer that offers health insurance coverage in the individual or small group market”).

⁵³ PPACA § 1201 (2010) (amending the Public Health Service Act to include § 2707(2) (subjecting a “group health plan” to the cost sharing limits set forth in PPACA § 1302(c)).

⁵⁴ See PPACA §1302(a)(2).

⁵⁵ PPACA §1302 (c)(2)(A)(ii) (2010).

⁵⁶ 42 USC § 2713 (preventive services requirements applicable to “group health plans”).

⁵⁷ 42 USC § 300gg-14.

⁵⁸ 42 USC § 2705 (j).

⁵⁹ 42 USC § 2705 (a).

⁶⁰ PPACA § 2717.

the employer will be penalized.⁶¹ In addition, states will have the option of giving large employers the choice to include plans offered through the Exchanges as part of their employer-sponsored plan, allowing employees to use pre-tax dollars to buy health plans on the Exchange.⁶² “Large” employers that are not very large are likely push states to make that option available.

2. DISTRIBUTING RISK AND RESPONSIBILITY AFTER THE ACA

After the Affordable Care Act takes full effect, the health care costs of the U.S. population will be distributed as follows.⁶³

Most healthcare costs associated with old age and total disability— apart from long term care – will be distributed through the Medicare program, as now.⁶⁴ Medicare is available to all lawfully present and working Americans and is financed through a flat percentage tax on wages paid over the lifetime and some income-based premiums paid while eligible for Medicare.⁶⁵ Medicare beneficiaries have cost-sharing obligations at the point of service that vary according to the kind of service, the most significant of which are capped at a new lower level by the Act.⁶⁶

Most healthcare costs of those with the lowest level of income will be distributed through the Medicaid program, as now but with the reduction in importance of the deserving poor

⁶¹ PPACA § 1513 (a) (2010) (amending the IRC by creating a new Section 4980H, subpart b of which imposes a \$3000/12 penalty per employee per month). Amy Monahan and Daniel Schwarcz argue that this penalty may not be enough to induce employers to design plans that will be sufficiently appealing to high risk workers, raising the possibility that employers will “dump” such workers on to the exchanges. *See* Monahan & Schwarcz, *supra* note ____ (providing a road map for an employer that was considering such an approach). Read carefully, their article contains a regulatory solution that is within the discretion of the Secretary of Health and Human Services to implement.

⁶² PPACA § 1312(f)(2)(B)(ii) (2010) (allowing this option starting in 2017).

⁶³ This discussion focuses on explicit health risk distribution mechanisms, omitting the healthcare financing provided through government-supported research, health construction and equipment, public health measures, and non-reimbursed state and local hospital expenditures. As calculated by the U.S. Centers for Medicare & Medicaid Services, Office of the Actuary, expenditures in these omitted categories totaled about seven percent of national health expenditures (\$158 billion of \$2.24 trillion in National Health Expenditures). *See* Table 128 U.S. Statistical Abstract (2010). This discussion also omits the healthcare costs of military families and veterans. These costs are distributed through general federal taxes. In 2007, Defense Department health benefits were \$31.7 billion and Veterans health benefits were \$33.8 billion.

⁶⁴ In 2007 Medicare expenditures were \$431.2 billion of the \$2.24 trillion in National Health Expenditures as calculated by the U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. *See* Table 128 U.S. Statistical Abstract.

⁶⁵ 26 USC §§ 3101, 3111; 42 USC §§ 402, 414a, 1395c, 1395j, 1395o, 1395r, 1395w-21, 1395w-101.

⁶⁶ This discussion does not address Medigap insurance, a form of private insurance (regulated by the federal government) that provides benefits that are supplemental to Medicare. *See generally*, Medicare.gov, *Medigap (Supplemental Insurance) Policies*, <http://www.medicare.gov/medigap/default.asp> (last visited Feb. 3, 2011).

categories.⁶⁷ Medicaid is financed through general revenues, principally from the federal government but also from state governments.⁶⁸

Healthcare cost risks attributable to employment – occupational injury and illness – will be largely distributed through the mandatory, state-based workers compensation system, as now.⁶⁹ Workers compensation health benefits are entirely paid for by employers through risk-based premiums (or self-insurance arrangements), but this cost is commonly understood to be borne in all or large part by employees in the form of foregone wages.⁷⁰ Assuming the Affordable Care Act succeeds, workers compensation health benefits may be merged over time into the general employment-based health benefit system.⁷¹

Other current healthcare cost risks of families with one or more members working for large employers will be distributed through the large group market, as now, but without giving employers the choice to opt out.⁷² In this market, all of the individual members of a group will pay the same premiums (subject to wellness rebates and risk classification by design), but the prices charged to each group will be based on the projected health care costs of that group, so there will be limited risk distribution among groups, especially very large groups.⁷³ This is the same as at

⁶⁷ In 2007, Medicaid and related expenditures were \$334.7 billion of the \$2.24 trillion in National Health Expenditures as calculated by the U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. See Table 128 U.S. Statistical Abstract. Because of the expansion of Medicaid, that number will grow much more rapidly in the short term than Medicare. It is important to be aware that a very large percentage of Americans are at risk of having such a low income at some point in their lives. Accordingly, it would be wrong to understand Medicaid as a program that primarily benefits a readily identifiable underclass.

⁶⁸ Lawrence D. Brown & Michael S. Sparer, *Poor Program's Progress: The Unanticipated Politics of Medicaid Policy*, 22 HEALTH AFFAIRS 31 (2003).

⁶⁹ 1-1 Larson's Workers' Compensation Law § 1.01 (LEXIS 2010)

⁷⁰ W. Kip Viscusi & Michael J. Moore, *Workers' Compensation: Wage Effects, Benefit Inadequacies, and the Value of Health Losses*, 69 Rev. Econ. & Statistics 249 (1987).

⁷¹ Indeed, allowing employers to satisfy their obligation to provide workers compensation health benefits by providing general employment-based health benefits could be a state-level incentive that encourages small employers to offer such benefits. Such a measure is likely to be very politically popular in light of (a) the increasing recognition within the business community that workers compensation has become an expensive form of health insurance and (b) the obvious efficiencies from eliminating the need to determine whether an injury or illness is caused by employment. In 2007, workers compensation health payments were \$32.4 billion of the \$2.24 trillion in National Health Expenditures as calculated by the U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. See Table 128 U.S. Statistical Abstract.

⁷² PPACA § 1513 (2010) (amending Chapter 43 of the Internal Revenue Code of 1986 to add a new section 4980H penalizing large employers that fail to offer full time employees the option to enroll in "minimum essential coverage"). See also PPACA § 1411(e)(4)(B)(iii) & f(2)(A) (procedure for notifying employer that employee is eligible for subsidies because the employer is not providing minimum essential coverage and for employer appeal of such determination)).

⁷³ Monahan & Schwacz at 10.

present. Individuals will have cost-sharing obligations at the point of service that are capped by the Affordable Care Act.⁷⁴

The current healthcare risks of all other individuals lawfully resident⁷⁵ in the U.S. will be distributed through state based Exchanges that attempt to combine all participants into a single risk pool in each state. Premiums will vary according to income, the type of plan selected, the application of the four permitted pricing factors (age, geography, family, and tobacco use), and, potentially, the wellness programs permitted in the small group market. Individuals will have cost sharing obligations that are capped at the same level as in the large group market.⁷⁶

From a prospective perspective, these health care cost spreading institutions distribute the risk of future healthcare costs among the U.S. population according to the share of applicable premiums and taxes paid by the subpopulations differentially assessed to finance these institutions. With any distribution of risk comes a distribution of responsibility.⁷⁷ The distribution of risk embodied in the new healthcare social contract rests on the following four individual (or family) responsibilities:

- The responsibility to pay taxes: (a) the wage taxes that finance Medicare and (b) the general taxes that finance Medicaid, the subsidies offered in the Exchanges, and the health care benefits provided to current and former military;
- The responsibility to obtain adequate health care benefits;
- For those who do not obtain health benefits through a government insurance program, the responsibility to pay premiums that reflect the fair share of the total health costs of the relevant health risk pool; and
- The responsibility to be as healthy as you can.

The first two of these are easy to understand and, in light of the preceding descriptions, need little explanation. Nevertheless, it is worth pausing to reflect on the degree to which tax-based financing rests on individual responsibility. The United State has a very high level of tax

⁷⁴ See PPACA §1302(a)(2); PPACA §1302 (c)(2)(A)(ii) (2010).

⁷⁵ The healthcare costs risks of individuals who are not lawful residents of the U.S. will not be distributed through any of these mechanisms. While this is a very important topic, it is part of a larger discussion about the increasingly punitive approach to illegal immigration that is beyond the scope of this essay.

⁷⁶ PPACA § 1302(c).

⁷⁷ See Tom Baker, *Risk, Insurance and the Social Construction of Responsibility*, in Baker & Simon, *supra* note __.

compliance.⁷⁸ This willingness to take responsibility provides reason to believe that Americans will accept their obligation to insure, especially if, as I will argue, the price charged for that insurance reflects widely shared moral values. The other two responsibilities require some more work on my part, because the Act does not explicitly address either “fair share” or “be as healthy as you can.” I will begin with fair share.

A. THE FAIR SHARE APPROACH TO RESPONSIBILITY FOR THE COST OF HEALTH CARE

The Affordable Care Act continues a long term trend in U.S. health care financing away from the ordinary market approach, in which people pay for their own health care services at the point of consumption. Increasingly, Americans have been paying what we might call their fair share of the overall cost of health care, primarily through insurance premiums and taxes and secondarily through cost-sharing at the point of consumption. The Act continues this fair share trend by expanding the private insurance market (through the mandates and subsidies), expanding Medicaid, reducing some of the cost sharing in Medicare, and placing new limits on the cost sharing permitted in private health plans.

What constitutes a fair share varies across time, space, and cultural context. In the U.S. fair share almost certainly will remain more closely linked to health care consumption than in cultures with less emphasis on autonomy and choice. But this link is contested and subject to administrative and political judgments that produce different results than would the decentralized health care consumption choices of individuals paying directly for those services.

After the Affordable Care Act, the fair share of health care costs paid by individuals will depend more on the ability to pay than on the amount of health care services consumed, and more on current choices than on inherited or earlier determined health risks. The fair share will depend more on the ability to pay than in the past because of the increase in Medicare taxes, the elimination of the deserving poor categories at the national level in Medicaid, and the new subsidies offered through the Exchanges. It will depend less on consumption than in the past because of the new limits on cost-sharing. It will depend less on inherited or earlier determined health risks because of the elimination of medical underwriting and the limits on individualized risk-based pricing. Finally, the fair share will come to depend more on some newly important current choices because of the responsibility to be as healthy as you can to be discussed shortly.

⁷⁸ See National Taxpayer Advocate 2007 Annual Report to Congress vol. 2, 138-50 (Marjorie E. Kornhauser, Normative and Cognitive Aspects of Tax Compliance).

Before moving to that topic, however, it is worth considering how the fair share approach of the Affordable Care Act compares to that of the traditional private market insurance arrangements that presently obtain in the individual and small group market.

The guiding principle of private market insurance pricing, outside of the employment benefit context, has been actuarial fairness.⁷⁹ In insurance economics, insurance pricing is actuarially fair if, and only if, the price charged to each person for the insurance exactly matches the expected value of the insurance to that person, as that value can be known using all of the available information (including private information known only to the person).⁸⁰ In practice, the concept of actuarial fairness cannot be this rigorous, because of transaction costs and private information.⁸¹ But, as applied, the concept of actuarial fairness has been almost as committed to individualized risk-based pricing as it is defined to be in theory.⁸² The main difference between practice and theory lies in the deference, in practice, to the convenience of insurance institutions, which have the discretion determine when the investment in making individualized risk assessments begins to exceed the return, and in legal restrictions on the categories that may be used to make pricing distinctions (e.g., no race, religion or national origin).⁸³

There are many things about actuarial fairness that interest law professors and other people used to thinking about fairness in other ways.⁸⁴ For present purposes, the most important thing to note is that, as the name of the concept reflects, actuarial fairness explicitly embodies an idea about what is fair.⁸⁵ Accordingly, all health insurance that is priced on an actuarially fair basis reflects a fair share approach to the responsibility to pay for the costs of health care. This explains why I described the extension of the fair share approach in the Affordable Care Act as the continuation of a very long trend. From the beginning, health insurance pricing in the U.S. has been based on – contested – ideas about what constitutes the fair share of the cost of the health care paid

⁷⁹ See Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. OF HEALTH, POLITICS, POLICY AND L. 287 (1993).

⁸⁰ See Scott E. Harrington & Gregory R. Niehaus, RISK MANAGEMENT & INSURANCE at 135 n.1 (2004).

⁸¹ See *id.* at 179-88.

⁸² See Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. OF HEALTH, POLITICS, POLICY AND L. 287 (1993).

⁸³ See Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L. J. 371.

⁸⁴ See, e.g., Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. R. 517 (1983); Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. & SOCIETY REV. 771 (1988); Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. CIVIL RIGHTS/CIVIL LIBERTIES L. R. 355 (1997).

⁸⁵ See generally Stone, *supra* note –.

for by the insurance pool that can or should be charged as premiums to the individuals who participate in the pool.⁸⁶ The Affordable Care Act extends the fair share approach to health care financing simply by paying for a greater percentage of health care services through insurance.

Actuarial fairness represents an expert approach to what constitutes a fair share that developed within the actuarial profession, as part of the profession's responsibility to protect the financial health of insurance institutions.⁸⁷ Actuaries are a powerful, if relatively unknown, profession. Their power derives from their claim to a disinterested, mathematical expertise, a claim that, like the core claims of other professions, is recognized in law through the grant of an exclusive legal authority. No new insurance product or price can be introduced in the U.S. without a certification from an actuary that the price to be charged for that product complies with state insurance law, meaning that it is "adequate, not excessive, and not unfairly discriminatory."⁸⁸

The concept of actuarial fairness became legally significant in relation to the "unfairly discriminatory" aspect of state insurance pricing law.⁸⁹ Within the framework of actuarial fairness, a price is unfairly discriminatory when two people presenting the same risk are charged different prices for the same product, but not when two people presenting different risks are charged different prices.⁹⁰ So, to use an example that received extensive discussion following the Supreme Court's decision in 1985 in *City of Los Angeles v. Manhart*, charging men and women different prices for annuities or life insurance is actuarially fair – and therefore not unfairly discriminatory – because men and women have different expected life spans and because expected life span is central to the computation of expected risk in relation to life insurance and annuities.⁹¹ In *Manhart* the Supreme Court held that Title VII of the Civil Rights Act prohibited the use of gender-based pricing for annuities in the employment context, notwithstanding the fact that men and women on

⁸⁶ See Baker, *Containing the Promise of Insurance*, *supra* note _____. Cf., Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. R. 237, 291 (1997) ("our insurance arrangements form a material constitution, on that operates through routine, mundane transactions that nevertheless define the contours of individual and social responsibility.").

⁸⁷ Cf., Timothy Alborn, REGULATED LIVES (describing the rise of the actuarial profession in 19th century Britain).

⁸⁸ See, e.g. O.C.G.A. § 33-9-21 (requiring Georgia's insurance companies to file their motor vehicle insurance rates with the state's insurance commissioner and placing the burden in any subsequent hearing upon the insurers to show that the rates are not excessive); M.C.L.S. § 500.2403 (same, applying to Michigan's casualty insurance rates).

⁸⁹ See Tom Baker, *Insurance Law and Policy* at 705-21 (2nd Ed. 2008).

⁹⁰ Id. At 711 (reproducing an excerpt of the National Association of Insurance Commissioners Model Unfair Trade Practices Act).

⁹¹ *City of Los Angeles v. Manhart*, 433 U.S. 702 (1978). See generally, Simon, *Actuarial Practices*, *supra* note -- (discussing *Manhart* and subsequent analysis by insurance and civil rights scholars).

average have different mortality, thereby limiting the application of the concept of actuarial fairness in that context.⁹²

The Affordable Care Act rejects the concept of actuarial fairness more completely than the Supreme Court did in *Manhart*. This rejection can be seen in the, clearly deliberate, use of the word “discrimination” in the Act to describe the ordinary, actuarially fair (in the loose, practical sense) risk-based decisions of the private insurance market. The Act prohibits “discriminatory premium rates” and all other “discrimination against individual participants and beneficiaries based on health status.”⁹³ “Discriminating” among individuals according to their health status is the fundamental characteristic of the actuarially fair approach to insurance, in which individuals pay according to the expected value that insurance has for them and insurance companies compete by identifying new ways to exclude the highest risk individuals from their pools.⁹⁴ By 2014 such discrimination will be illegal throughout the U.S. health insurance market.

⁹² *Manhart*, 433 U.S. 702.

⁹³ Section 1201 of PPACA amends the ____ to state:

42 U.S.C. § 2701 FAIR HEALTH INSURANCE PREMIUMS.

(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

....

42 U.S.C. § 2705 PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

⁹⁴ See Stone, *supra* note __ at 308:

The Affordable Care Act does not reject all aspects of actuarial fairness, however. In addition to permitting some individual variation in prices on the basis of the four permitted pricing factors listed in section 1201 (individual/family, geographic region, age, and tobacco use), the Affordable Care Act retains the link between price and expected value. But, the Act shifts the relevant measure of expected value from the individual to the group, in line with the approach that already prevails in the large employment group market. In that market, existing law prohibits differential pricing among members of an employment group.⁹⁵ The Affordable Care Act extends that non-discrimination approach to the individual and small group market by treating all of the people buying insurance through each state-based exchange as a single, very large group, similar to the federal employee health program. Prices in the individual and small group market are to be based on the health care costs of the entire pool of people purchasing through the exchange, subject to differentials based on the four factors and to differences in the actuarial value and other design features of the plans.

To summarize, the Affordable Care Act extends the fair share approach to health care financing by bringing more people under the health insurance umbrella. At the same time, the Act extends the non-discrimination vision of what constitutes a fair share from the large employment group market into the individual and small group market. Vestiges of individualized actuarial fairness will remain. Some of those vestiges are explicitly authorized, for example, the permitted pricing factors in the individual and small group market. Other vestiges – such as risk classification by design – are not authorized and will constitute a continuing challenge to achieving the universal coverage and non-discrimination goals of the Affordable Care Act. These challenges are addressed in part 3.

B. THE RESPONSIBILITY TO BE AS HEALTHY AS YOU CAN

The Affordable Care Act points toward a new responsibility to be as healthy as you can. This emerging responsibility needs to be teased out a bit from within the Act, but it is consistent with other developments in social welfare policy, such as the shift to defined contribution pension plans, and with ideas from health economics and health ethics. The Act promotes this new health

The logic and methods of actuarial fairness mean denying insurance to those who most need medical care. The principle actually distributes medical care in *inverse* relation to need, and to the large extent that commercial insurers operate on this principle, the American reliance on the private sector as its main provider of health insurance establishes a system that is perfectly and perversely designed to keep sick people away from doctors.

⁹⁵ 29 U.S.C. § 1182.

responsibility by reducing the cost of being healthy in two main ways: through the elimination of cost-sharing for designated preventive services,⁹⁶ by authorizing rebates and other rewards for participation in wellness programs.⁹⁷ The new preventive services rules extend across all private markets and Medicare. Initially, the wellness programs are authorized universally only for employer health plans, but Act authorizes the creation of pilot wellness programs in the individual market in up to ten states, starting in 2017.⁹⁸ If those are successful, it is not hard to imagine bringing similar incentives into Medicare, and perhaps even Medicaid.

For present purposes, the most important wellness provision appears in the anti-discrimination section discussed earlier, that “prohibiting discrimination against individual participants and beneficiaries based on health status.”⁹⁹ This provision authorizes group health plans to adopt wellness programs that provide as much as a 30% rebate of the premiums to participating members (with the possibility of rebates up to 50% in the future).¹⁰⁰ The cap on the allowable rebate is based on the total premium paid for the participating individual, including the portion of the premium paid by the employer. Accordingly, the rebate could easily exceed the employee’s share of the premium in some cases.

The location of the wellness program provision in the anti-discrimination section of the Act and the prohibition of wellness programs that are a “subterfuge for discriminating based on a health status factor”¹⁰¹ make clear that the responsibility embodied in the Act is not the responsibility to be healthy, but rather the responsibility to be as healthy *as you can*. Otherwise, the responsibility would conflict with the non-discrimination principles embodied in the Act. Not

⁹⁶ See, e.g., PPACA 1001 (creating 42 U.S.C. § 2713, which requires private health plans to cover designated preventive services). In addition to the nationally designated preventive services, employers are permitted to eliminate or reduce the cost-sharing requirements for other “preventive care related to a health condition” without violating the non-discrimination provisions of the Act. 42 U.S.C. § 2705(j)(2)(C) (authorizing employers to establish “A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits)”).

⁹⁷ See PPACA § 1201 (creating 42 U.S.C. § 2705) The regulations promulgated by the NAIC and approved by HHS under the Act allow insurers to include the rebates and rewards as health care quality expenses for purposes of the new medical loss ratio. See Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74864, 74875, 74880 (interim final rule Dec. 1, 2010 (to be codified at 45 C.F.R. pt. 158) (indicating that wellness program expenses may qualify as expenses to improve health care quality and that expenses to improve health care quality may be included in the numerator for the computation of the MLR)..

⁹⁸ 42 U.S.C. § 2705 (l). See also PPACA § 4205 (authorizing grants for community based wellness programs)

⁹⁹ 42 U.S.C. § 2705.

¹⁰⁰ 42 U.S.C. § 2705(j)(3)(B).

¹⁰¹ 42 U.S.C. § 2705(j)(3)(B).

everyone has the opportunity to be healthy, but everyone has the opportunity to try to be as healthy as they can.

Consistent with the non-discrimination approach, the Affordable Care Act distinguishes between wellness programs that offer rewards “based on an individual satisfying a standard that is related to a health status factor” and those that do not offer such rewards.¹⁰² Programs that do not offer such rewards are not regulated, except for the requirement that the programs be “made available to all similarly situated individuals.”¹⁰³ Wellness programs that are open to everyone and that do not have rewards based on health status do not threaten the non-discrimination goal to nearly the same extent as programs that offer rewards based on health status.¹⁰⁴

Wellness programs that offer rewards for satisfying a health standard must be “reasonably designed to promote health or prevent disease,” meaning that the program:

- “has a reasonable chance of improving the health of, or preventing disease in, participating individuals,”
- “is not overly burdensome,
- “is not a subterfuge for discriminating based on a health status factor, and
- “is not highly suspect in the method chosen to promote health or prevent disease.”¹⁰⁵

The rewards “shall be made available to all similarly situated individuals” and shall allow for “a reasonable alternative standard (or waiver of the otherwise applicable standard)” for individuals for whom it is “unreasonably difficult due to a medical condition” or “medically inadvisable” to

¹⁰² The Act contains a safe harbor provision identifying specific programs that will not be subject to further regulation.

(A) A program that reimburses all or part of the cost for memberships in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

creating 42 U.S.C. § 2705 (j)(3))

¹⁰³ 42 U.S.C. § 2705 (j)(2))

¹⁰⁴ My intuition is that the take up rate for wellness programs will correlate with health status in at least some instances, however. I predict that free gym membership will be more utilized by the healthy while rewards for diagnostic testing will be more utilized by the less healthy.

¹⁰⁵ 42 U.S.C. § 2705(j)(3)

satisfy or attempt to satisfy “the otherwise applicable standard.”¹⁰⁶ Taken together, these requirements authorize rewards that are based exclusively on current, feasible efforts to maintain or improve health. Rewards based on past efforts or based on current efforts that are not feasible would be reflected in a “health status factor,” and discrimination on that basis is prohibited. A rebate for *being* healthy amounts to the same thing as a lower price for being healthy. By contrast, a rebate for *effort* to maintain or improve health can be made available to everyone, and the efforts of those currently in poor health may be the most valuable to the pool and, thus, most worthy of reward.

As this suggests, the overall spirit of the Act strongly suggests that wellness program rewards should be commensurate with the burden to the individual (the effort required to qualify for the reward) and the benefit of that effort to the risk pool (the future health care costs avoided). In economic terms, calibrating the reward to individual burden and the benefit to the pool aligns the interests of the individual with that of the pool, managing the moral hazard of health insurance.¹⁰⁷ In ethical terms, calibrating the reward to effort comports with widely accepted notions of desert, and calibrating the reward to the benefit to the pool reflects the link between individual responsibility and a greater good.¹⁰⁸ Views about what constitutes a greater good are far from uniform in a pluralist society, but there is widespread support for the idea that the growth in health care costs should be checked. The Affordable Care Act strongly reflects economists’ understanding of health insurance markets, including the idea that health care costs should be managed to benefit society. In addition, the Act strongly reflects the belief that the distribution of healthcare costs should not depend on brute luck.¹⁰⁹ These are some of the reasons why I conclude that the burden/benefit approach to wellness rebates and rewards is consistent with the Act.

The responsibility to be as healthy as you can reflects a trend in the approach to insurance, risk, and responsibility that Jonathan Simon and I have called “embracing risk” – an approach that is characterized by “policies that embrace risk as an incentive that can reduce individual claims on

¹⁰⁶ 42 U.S.C. § 2705(j).

¹⁰⁷ Cf. Mark V. Pauly & Philip J. Held, *Benign moral hazard and the cost-effectiveness analysis of insurance coverage*, 9 J. OF HEALTH ECON. 447 (1990).

¹⁰⁸ See generally, Harald Schmidt, *Bonuses as Incentives and Rewards for Health Responsibility: A Good Thing?*, 33 J. MEDICINE & PHILOSOPHY 198 (2008) (analyzing bonuses for health related behavior in the German social health insurance).

¹⁰⁹ See Allison K. Hoffman, *Three Models of Health Insurance: The Theoretical Incoherence of the ACA* (regarding brute luck)

collective resources.”¹¹⁰ These policies include the shift from defined benefit to defined contribution pensions,¹¹¹ the shift to investment-linked life insurance products,¹¹² the political support for good driver discounts in automobile insurance, efforts to “end welfare as we know it,” and the widespread increase of risk-bearing in the commercial insurance market through self-insured retentions, retrospective premiums, and captive insurance companies and other alternative risk products.¹¹³ All these policies represent efforts to use risk spreading institutions to encourage individuals to govern their own lives in a socially responsible manner.¹¹⁴

C. FAIR SHARE AND THEORETICAL INCOHERENCE

As Allison Hoffman’s Article in this Symposium explains, the Affordable Care Act reflects competing moral visions of health insurance: a “true security” vision reflected in the ability-to-pay aspects of the Act; a “maximizing health” vision reflected in the pay for quality, preventive care and other cost-benefit aspects of the Act; and a vision of protecting people from “brute luck” most clearly reflected in the non-discrimination and wellness aspects of the Act, and also, to the extent that differences in income are understood to reflect brute luck, in the ability-to-pay aspects.¹¹⁵ Each of these visions implies a different approach to fair share.

Professor Hoffman is surely correct that the presence of different moral logics means that the Act lacks theoretical coherence,¹¹⁶ and her effort to articulate and disentangle these logics represents a significant contribution to understanding. Nevertheless, I do not think the conflict reflects poorly on the drafters of the Act or increases the degree of difficulty of the challenges that will arise in implementation. Almost by definition, any major piece of legislation enacted through any reasonably democratic process in a heterogeneous society will be theoretically incoherent. People have different ideas about what constitutes a just society, and major legislation consciously directed at moving a nation toward a “more perfect union” necessarily will have to accommodate more than one vision.

¹¹⁰ Baker & Simon, *supra* note – at 3-4.

¹¹¹ Edward Zelinsky, *The Ownership Society: How the Defined Contribution Paradigm Changed America* (2008).

¹¹² See Pat O’Malley, *Imagining Insurance: Risk, Thrift and Life Insurance in Britain*, in Baker & Simon.

¹¹³ See, e.g., Harrington & Niehaus at 550 et seq..

¹¹⁴ Cf. Nikolas S. Rose, GOVERNING THE SOUL: THE SHAPING OF THE PRIVATE SELF (a dystopian analysis of this neoliberal approach to governance); Nietzsche, ON THE GENEALOGY OF MORALS (arguing that contract law first required the development of people able to keep promises).

¹¹⁵ See generally, Allison K. Hoffman, Three Models of Health Insurance: The Theoretical Incoherence of the ACA.

¹¹⁶ *Id.*, at __ [will need pincite once her article is paginated]

In practical terms, I see a hierarchy in the Act that will reduce the conflict among the visions in application. The true security vision is paramount, not because it is more widely accepted or more demonstrably correct, but rather because the portions of the Act that reflect this vision require little or no discretion to implement. There are formulas for Medicaid eligibility, for calculation of the subsidies administered through the Exchange, for the payment of Medicare taxes and premiums, and for the maximum individual cost-sharing. Thus, whatever theoretical conflict there may be between true security, on the one hand, and maximizing health and protecting people from brute luck, on the other, that theoretical conflict will not lead to practical conflicts in implementing the Act.

There may be some practical conflicts in implementing the aspects of the Act that address brute luck and maximizing health, but here I see a separation of spheres that will help administrators make practical decisions. The maximizing health and brute luck aspects of the Act have different targets. The maximizing health aspects of the Act are primarily directed at the medical care that individuals are entitled to receive through their health insurance, while the brute luck aspects are primarily directed at the price that individuals have to pay for their health insurance and, through cost-sharing, for their health care at the margin. Of course, the price of health insurance and the extent of cost-sharing can affect the care that individuals actually receive, but the true security aspects of the Act reduce the practical significance of this theoretical possibility by reducing the cost of insurance and the amount of cost-sharing according to people's ability to pay.

Accordingly, I think that the theoretical incoherence can be reconciled in the following manner. The ceiling on individuals' fair share is fixed by the true security aspects of the Act. For those with the highest incomes, the ceiling equals the total premiums plus the maximum permissible cost-sharing. That ceiling goes down with income, reaching zero at 130% of the poverty index. The brute luck aspects of the Act limit the degree to which the market price for insurance may reflect the health risk of any individual, while allowing rewards for healthy behaviors that will reduce individuals' actual payments below the true security ceiling. Finally, the maximizing health aspects of the Act will affect what medical services are covered by insurance and which services are subject to the preventive care prohibition on cost sharing, with the resulting impact on the aggregate costs that are divided on a fair share basis.

Wellness programs are the one obvious place where brute luck and maximizing health will come into contact. But here, I see the two as complementary rather than in competition. The brute luck idea says that different payments based on different effort are morally and politically acceptable, but the brute luck idea does not provide a precise guide to the amount of the different payments. Maximizing health supplies that guide, by counseling that the rewards should be proportional to the effort required to receive them and to the social benefit of that achievement, as measured by the reduction in the costs to the health insurance pool.

3. CHALLENGES TO THE NEW HEALTHCARE SOCIAL CONTRACT

The insurance market reforms in the Affordable Care Act present a host of technical challenges that will keep regulators, lobbyists, and health benefit consultants more than fully employed over the next few years. The Act delegates many of the key line-drawing decisions to the Secretary of Health and Human Services, such as the definition of essential health benefits and the final determination of what counts as a medical expense for purposes of the medical loss ratio requirements. The staffs of HHS, Treasury, and the Department of Labor have been issuing regulations and requests for comment at a rapid rate, so far meeting the extraordinarily short deadlines imposed by the Act.¹¹⁷

For their part, the states have to work together through the National Association of Insurance Commissioners to address national issues such as the medical loss ratio, and they have to create the regulatory framework for the Exchanges, find contractors that can assemble the necessary hardware and software, and work with HHS to create a uniform framework for data feeds to and from the Exchanges. Insurance companies and group health plan administrators will have to stay abreast of all these developments and design their systems and services in compliance with them. As important and daunting as all these tasks may be, they are the kinds of implementation challenges that would accompany any major reform of a significant market and, thus, they are not challenges to the core values reflected in the Affordable Care Act.

Apart from the political backlash that I do not have any particular expertise in analyzing, I see just two major challenges to the core values embodied in the insurance market regulation portions of the Act: risk classification by design and non-compliance with the mandates. Risk

¹¹⁷ The Center for Consumer Information and Insurance Oversight maintains a website with the latest regulations and guidance. See <http://www.hhs.gov/cciio/regulations/index.html>.

classification by design would separate people into different risk pools through the design of health plans that appeal differentially to people in ways that correlate with health status, challenging the core non-discrimination value embodied in the Act. Non-compliance with mandates would take people out of the health insurance risk pool, threatening the core solidarity value embodied in the Act.

As explained in detail shortly, the Act contains measures that regulators can use to limit risk classification by design. In my view, partial success in this regard is all that can reasonably be expected, given the continued reliance on private market insurance. Moreover, the partial “failure” will simply mean that more actuarial fairness survives than the Act’s drafters may have intended. Actuarial fairness is a longstanding, well pedigreed approach with many supporters, not all of whom are insurance industry apparatchiks. The Affordable Care Act represents a compromise between competing values and thus it should be no surprise – and not of overwhelming concern – that the distribution of the costs of essential health care services will reflect a tension between competing approaches to distributing the costs of health care, in this case non-discrimination and actuarial fairness. The Act directs regulators to contain and limit actuarial fairness in health care financing, not to eliminate it.

Carefully considered, non-compliance with the mandates poses a similar kind of challenge. Because everybody can always choose to sign up for health insurance (at least once a year) and because low income individuals can always qualify for Medicaid, non-compliance with the mandates does not fundamentally threaten access to healthcare. Rather, non-compliance poses a challenge to risk sharing, similar to risk classification by design.

A. RISK CLASSIFICATION BY DESIGN

Risk classification by design is my new term for the economic phenomenon that Joseph Stiglitz explored in his Nobel prize winning work on markets with asymmetric information. In a foundational paper with Michael Rothschild published in the 1970s, Stiglitz developed a model that showed how insurance firms can use insurance product design to solve the “lemons problem” that Stiglitz’s co-prize winner, George Akerlof, had identified in the 1960s.¹¹⁸

¹¹⁸ See Michael Rothschild & Joseph E. Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 630 (1976); George A. Akerlof, *The Market for ‘Lemons’: Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488 (1970).

In brief, a lemons problem results when sellers know the quality of the goods that they are selling and buyers do not. Akerloff developed the economic insight using a mathematical model that he explained by asking readers to imagine a used car market composed of two kinds of cars: high quality cars (he called them “peaches”) and low quality cars (“lemons”).¹¹⁹ As he explained, if buyers don’t know whether they’re getting a lemon or a peach, they are not going to pay a peach price.¹²⁰ Instead, they will pay something like the average price.¹²¹ But, if the owner of a peachy car can’t get a peachy price, he’s not going to be as interested in selling it.¹²² So, we can readily see that the used car market in this imagined world would contain more lemons than peaches, meaning that the average value of the cars in that market would be less than the midpoint between lemons and peaches, reducing the price that buyers would be willing to pay, driving even more peaches out of the market, and so forth.

As Akerloff pointed out, an insurance market has some of the same features, considered from the perspective of the insurance company.¹²³ Some insurance buyers are low risk “peaches” and other insurance buyers are high risk “lemons,” and in many cases the insurance buyers have at least some sense of whether they are lemons or peaches. If the insurance company can tell the difference between lemons and peaches, it will charge the peaches a peach price and the lemons a lemon price (consistent with actuarial fairness), and the market will work just fine (as long as the lemons can afford the lemon price, though Akerloff wisely didn’t address that problem in his theoretical treatment). If insurance companies aren’t able to tell the difference between lemons and peaches, however, or if they are prevented from charging different prices, then they will have to charge all of the buyers the same price. This will be a price that will be higher than at least some of the peachy (low risk) buyers are willing to pay. So the people who choose to buy insurance will be disproportionately high risk, requiring the insurance company to raise the price, driving more of the low risk buyers out of the pool, and so on.¹²⁴ This is the dynamic that 19th century insurance actuaries first called “adverse selection,”¹²⁵ and it has been a very real problem in the individual

¹¹⁹ Akerloff at ____.

¹²⁰ *Id.* at ____.

¹²¹ *Id.* at ____.

¹²² *Id.* at ____.

¹²³ *Id.* at ____.

¹²⁴ The insurance contract – which is not understandable by most consumers – presents the same informational asymmetry from the buyers’ perspective as well. Regulation of the contents of the insurance contract helps to solve that problem. See Tom Baker, *INSURANCE LAW AND POLICY: CASES, MATERIALS AND PROBLEMS* 641-43 (2008).

¹²⁵ Baker, *Containing the Promise*. To a very substantial extent, all of the 20th century advances in the economics of information represent the formalization of the hard won practical knowledge the insurance industry gained in the 19th century. See Tom Baker, *On the Genealogy of Moral Hazard*. See also Interview with Kenneth Arrow,

and small group health insurance market, particularly when companies are prohibited from charging actuarially fair prices.¹²⁶

Stiglitz – the son of an insurance agent¹²⁷ – recognized that insurance markets do not always fall apart in real life, even when buyers have private information about their peachiness. In his paper with Rothschild he showed in mathematical terms that insurance products can be designed to appeal differentially to people with different risk characteristics, so that people self-select into separate risk pools in a manner that correlates with their risk status.¹²⁸ Subsequent empirical research, most significantly in the context of cafeteria style health care employment benefit plans, has demonstrated the Stiglitz’s theoretical predictions are borne out in practice.¹²⁹ High health risk people tend to prefer more complete health insurance coverage, fewer restrictions on their choice of doctors, and other plan features that make it easier to consume more health care.¹³⁰ As a result, cafeteria-style employment health benefit plans tend to produce some risk separation, especially if the portion of the premiums paid by the employees reflects the differences in the health care costs among the sub-pools.¹³¹ Insurance economists refer to this dynamic as adverse selection,¹³² but adverse selection is such a multi-faceted and generalizable phenomenon that I think we need a more specific name for this example. I suggest that we call it risk classification by design.

The Affordable Care Act contains four main tools to reduce risk classification by design in the individual and small group market: the minimum coverage requirements, the Exchange certification requirement, the medical loss ratio, and, most obviously, the risk adjustments. The paragraphs that follow explain how each of these tools can be used, with the greatest attention given to risk adjustments.

<http://mpira.ub.uni-muenchen.de/967/> (reporting that he first learned about adverse selection and moral hazard when studying for his actuarial exams in the 1940s).

¹²⁶ See, e.g., Anemona Hartocollis, *New York Offers Costly Lessons on Insurance*, *The New York Times* April 17, 2010 (reporting adverse selection spiral in New York HMO market subject to community rating law).

By ANEMONA HARTOCOLLIS

¹²⁷ Nobelprize.org, *Joseph E. Stiglitz – Autobiography*,

http://nobelprize.org/nobel_prizes/economics/laureates/2001/stiglitz.html# (last visited Feb. 3, 2011).

¹²⁸ Stiglitz at ____.

¹²⁹ For a review of the research, see Cohen & Siegelman, *supra* note --.

¹³⁰ *Id.* at ____.

¹³¹ Cohen & Siegelman, *supra* note ____ at 62 (summarizing a study of Harvard’s health plan). Note that recent research suggests that advantageous selection – i.e. low risk people preferring the higher price insurance in some situations – may partially offset the adverse selection in some situations. Hanming Fang, Michael P. Keane & Dan Silverman, *Sources of Advantageous Selection: Evidence from the Medigap Insurance Market*, 116 *J. POL. ECON.* 303 (2008).

¹³² See generally Cohen & Siegelman, *supra* note ____.

1. MINIMUM COVERAGE REQUIREMENTS

Minimum coverage requirements have the potential to reduce classification by design in two ways. First, because the “essential health benefits” are likely to include all or most of the health benefits that most people need, there is less room for variation in plans that can be used to segment people into separate risk groups. Second, the minimum coverage requirements make it easier for regulators to compare plans to identify differences in design that could lead to classification by design. As discussed next, the Act specifically directs the Secretary of Health and Human Services to regulate the Exchanges to reduce the likelihood of classification by design, and the Exchanges will have broad discretion that could be used to the same end.

2. THE EXCHANGE CERTIFICATION REQUIREMENT

In order to be sold through the Exchange a health plan must be certified by the Exchange. The Affordable Care Act directs the Secretary to develop regulations governing the certification process. Significantly, the Act states that the certification requirements shall include the requirement that a plan “not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.”¹³³

The Act also grants the Exchanges broad discretion to consider the public interest in deciding whether to certify a plan. The Act states:

- An Exchange may certify a health plan as a qualified health plan if—
- (A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection(c)(1); and
 - (B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, . . .¹³⁴

Using the authority granted by this provision, an Exchange could refuse to certify a plan on the grounds that it could lead to risk classification by design, contrary to “the interests of qualified individuals and qualified employers.”

It is almost certainly the case that some plan designs that could lead to some risk segmentation are nevertheless in the public interest. For example, a plan with a tightly controlled network that employs aggressive performance based payments systems might be comparatively

¹³³ PPACA § 1311(c)(1)(A).

¹³⁴ PPACA § 1311(e)(1).

unattractive to a high income, high risk population, thus leading to some risk classification by design. Nevertheless, I would encourage regulator to allow these plans to offer a lower cost alternative to people willing to trade some choice and convenience and to place some market pressure on provider prices. As this suggests, there are good reasons to tolerate at least some ‘disparate impact’ risk segmentation, to borrow a term from the civil rights discrimination context. What the Act seems clearly to prohibit is, to continue with the discrimination law analogy, disparate treatment risk segmentation – i.e. plan design deliberately crafted to appeal to a low risk population. The certification requirement is one tool that Exchanges can use to prevent such deliberate risk segmentation.

3. THE MEDICAL LOSS RATIO REQUIREMENTS

The Affordable Care Act requires all health plans to meet minimum medical loss ratios, a concept that refers to the ratio of medical expenses paid by a plan to the premiums collected by the plan.¹³⁵ A minimum loss ratio requires a plan to spend at least the designated percentage of its premiums on medical and health care quality expenses. The Act defines the minimum medical loss ratio for individual and small group plans to be 80% and for large group plans, 85%. Plans that do not meet these requirements will have to refund a portion of the premiums collected in order to come into compliance.¹³⁶

Minimum loss ratios discourage risk classification by design because the loss ratios limit the return that a firm can earn on classification by design. Traditionally, a major goal of risk selection was to increase profits by offering low risk individuals a price that was sufficiently less than the price charged by the less adept competitor in order to attract the loss risk business, but not so much less that the insurer would disgorge to the low risk customers all of the medical cost savings that resulting from using risk selection to “improve” the insurer’s risk pool. In theory and in the long run competition would prevent insurance firms from earning such excess returns, but economic theory rarely discourages firms from vigorous efforts to earn short term profits.

The minimum loss ratio takes away these short term profits by requiring a successful cream skimming insurer to return to its policyholders all or most of the benefits of the cream skimming. A simple example illustrates how this would work.

¹³⁵ See generally, James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, 16 HEALTH AFFAIRS 176 (1997).

¹³⁶ 42 U.S.C. § 300gg-18.

Imagine Akerloff's population of insurance buyers, consisting of low risk peaches and high risk lemons. The Affordable Care Act prohibits insurers from charging different prices to peaches and lemons and obligates both peaches and lemons to buy insurance. The Affordable Care Act ideal is for peaches and lemons to each pay the average price (subject to the permitted pricing variations, all of which are based on easily observable characteristics).

Now imagine that Crafty InsureCo figures out how to design a health plan that is more appealing to peaches than lemons. Crafty could of course charge a price for the health plan that is precisely fitted to the mix of lemons and peaches expected to buy the plan, in which case the plan would be much less expensive than the other health plans (because health care lemons are much more expensive to insure than health care peaches). But in that case Crafty wouldn't get much in the way of profit in return for all that effort. Besides, Crafty doesn't need to do that in order to get the peaches to sign up, because they prefer the Crafty plan. So Crafty charges a bit less than the competition, gets most of the peaches to sign up for the Crafty plan, and earns truly excellent short term profits. (In the long run and in theory this won't work. But, as Keynes famously observed, in the long run we are all dead.)

The medical loss ratios take the excellent short term returns almost completely out of this picture. If Crafty's premiums significantly exceed medical expenses, Crafty has to return the excess premiums to the policyholders. Crafty might still want to innovate in order to keep or increase market share, but Crafty's upside is limited, especially in relation to cheap-to-insure customers. Let's do the math, in very simple terms: The absolute maximum Crafty can keep from the premiums, after medical expenses, is 17.5% of the total amount spent on medical expenses.¹³⁷ That 17.5% has to be used to cover all of Crafty's other expenses: marketing, innovation, administration, and paying for the CEO's jet. 17.6% of the medical expenses for a population of mixed peaches and lemons is more than 17.6% of the medical expenses for a population of peaches. That means more money to pay for the CEO's jet.

4. THE RISK ADJUSTMENTS

As explained in part 1, the Affordable Care Act directs the Secretary of Health and Human Services to create a risk adjustment procedure for plans offered through an Exchange to equalize risk sharing among the participants in the Exchange. Plans that are populated by people with lower

¹³⁷ The permitted 15% of the premiums that is excess to the minimum 85% of premiums that must be spent on medical expenses is 17.6% of the 85%. Think of it this way: \$15 is 17.6% of \$85.

average levels of health risk are supposed to make payments to plans that are populated by people with higher average levels of health risk. This way, the premiums paid will reflect each individual's fair share of the total Exchange pool, rather than the pool of the particular plan. Risk adjustment technology is still in its infancy and, thus, the ability of HHS to fully achieve the solidarity aims of the statute will depend on advancement in this field.¹³⁸ It is worth noting that the existing research suggests that risk adjustments can be less complicated in practice as might first appear.¹³⁹ The key realization is that, as long as individuals in the pools have health care records, it is possible to do a rough risk adjustment in advance. Individuals pay an average price (subject to the permitted pricing variations), but the difference between this average price and their individualized risk-based price is either paid to or received from the risk adjustment mechanism.¹⁴⁰ One interesting corollary to these ex ante risk adjustments is that the non-discrimination norm of the Affordable Care Act will not eliminate the demand for individualized risk assessment technology. Instead, it will simply shift the application of that technology from individualized pricing to the risk adjustment process.

B. NONCOMPLIANCE WITH THE MANDATES

Of all the features of the Act, the individual mandate has received the greatest attention in the post-enactment political debate. There are two main critiques: the mandate is unconstitutional and the penalties for violating the mandate are under-powered. I will address only the latter here. In summary, I have two responses. First, the penalties are better-powered than commonly believed, especially when understood in context. Second, there is reason to believe that the exchanges can succeed even with substantial non-compliance. To the extent that the non-compliant are lower risk, there will be less risk-spreading through the Exchanges, but that will principally affect the cost of health insurance for people who are better able to pay for it.

1. *THE PENALTIES ARE BETTER POWERED THAN MANY PEOPLE REALIZE*

To predict the impact of the penalties on compliance it is necessary to focus on more than just the size of the penalty in relation to the price of health insurance. From a practical perspective,

¹³⁸ Heiss, Florian, et al., *Regulation of private health insurance markets: Lessons from enrollment, plan type choice, and adverse selection in Medicare Part D*, NBER Working Paper No. 15392 (Oct. 2009); Meenan, Richard T. et al., *Using Risk Adjustment Models to Identify High Cost Risks*, 41 *MEDICAL CARE* 1301 (2003); Wynand P.M.M. Van ed Ven, *Risk Adjustment in Competitive Health Plan Markets*, in A.J. Culyer and J.P. Newhouse, eds, *HANDBOOK OF HEALTH ECONOMICS*, Vol. 1 at 757 (2000).

¹³⁹ See Meenan et al, *supra* note --.

¹⁴⁰ *Id.*

the most important thing to focus on is the longstanding cultural commitment in the U.S. to legal obligations that are understood to be legitimate. Nevertheless, because it is hard to quantify that commitment and because the constitutional challenge to the mandate and the other aspects of the political backlash may delegitimize the mandate for some people, I will set that commitment aside and consider only immediate self-interest, focusing on the situation of a self-employed individual thinking about whether to purchase insurance on the Exchange.

There are four moving pieces to consider in a rational choice approach to compliance through the individual Exchange: the list price of health insurance on the Exchange, the amount of the subsidy available to the purchaser for that insurance, the penalty for non-compliance, and the value of the insurance to the purchaser. Too much of the discussion about compliance focuses only on the relationship between the list price for insurance and the penalty, without considering either the subsidy or the fact that people are willing to pay something for health insurance. In rational choice terms, the relevant relationship is that between the *net price* that people face for insurance on the Exchange and the amount that they are willing to pay for that insurance. In that context, the right way to think about the penalty is as a kind of subsidy. The presence of a penalty for not buying insurance reduces the net price of insurance. The net price is the list price minus the subsidy *and* minus the penalty that people who comply with the mandate will not have to pay.

There are a few things that can be said in general about the net price for an individual subject to the mandate. First, the penalty does appear to be administratively enforceable, albeit not perfectly so. Provided that an individual properly files a tax return (which the vast majority of Americans do¹⁴¹), the Internal Revenue Service will know who is uninsured and will assess the penalty. While the statute prohibits the IRS from using its most extreme enforcement measures (criminal prosecutions and liens),¹⁴² the IRS Commissioner has stated that the IRS may withhold refunds and that it will have other ways to collect the penalty.¹⁴³

Second, the maximum net price for the relevant plan on the Exchange for an individual subject to the mandate will be about six percent of income, which is less than an employee's share of the Social Security tax (which appears as the FICA tax in the information supplied to an employee

¹⁴¹ See IRS, *supra* note --.

¹⁴² PPACA Ch. 48(f)

¹⁴³ Timothy Noah, *Maybe the Individual Mandate IS Enforceable: The IRS Commissioner Explains How He'll Make You Buy Health Insurance*, SLATE <http://www.slate.com/id/2250098/> (Apr. 7, 2010) (quoting IRS Commissioner Douglas Shulman at the National Press Club on April 5, 2010)

with his or her paycheck), currently set at 6.2% of income up to \$106,800 in 2010,¹⁴⁴ and less than the 8.6% average percentage of gross income paid for health benefits in the employment context.¹⁴⁵ If the average is 8.6% that means that many employees, especially lower income employees, are paying a much higher percentage, mostly in the form of forgone wages.

Here is how I arrived at the six percent of income maximum net price. No one is subject to the mandate unless his or her “required contribution” to purchasing health insurance is more than eight percent of income. (The “required contribution” is the premium for the lowest priced Bronze plan minus the subsidy available through the Exchange.)¹⁴⁶ If the individual is subject to the mandate, the penalty for not buying insurance is the greater of (a) \$695 per person in 2016, indexed for inflation thereafter, up to a family maximum of three times the individual rate (with children subject to a penalty of 50% of the adult penalty, so that the maximum penalty is reached with a family of four), or (b) 2.5% of income above the income tax filing threshold.¹⁴⁷ Subtracting the 2.5% penalty from the 8% maximum price leads to a net price of 5.5%, which I increased by .5% to reflect the fact that the penalty is not assessed on the income below the filing threshold to arrive at the “about six percent of income maximum net price.”

Third, because of there is a minimum penalty that will be more than 2.5% of net income for many lower income people, the net price will be a lower percentage of income for many households. The \$695 minimum individual penalty is more than the 2.5% penalty for any

¹⁴⁴ 26 U.S.C. § 3101. The Medicare tax is in addition to the Social Security tax. *Id.*

¹⁴⁵ Employee health benefits represented 6.6% of employers total cost of compensation during the last decade. See Kaiser Family Foundation, *Wages and Benefits: A Long-Term View* (Nov. 2009), <http://www.kff.org/insurance/snapshot/chcm012808oth.cfm> (showing benefits as a share of total compensation by decade in Figure 3). Employees’ share of the cost of health benefits grew now represents 30% of the total. See Kaiser Family Foundation, *Employer Health Benefits 2010 Annual Survey*, <http://ehbs.kff.org/>. This means that people who obtain their health insurance through work presently pay, on average, 8.6% of their gross income for that insurance. Most of that “payment” is in the form of foregone wages.

¹⁴⁶ PPACA § 1501(e)(1) (exempting from the mandate individuals whose “required contribution” exceeds 8% of income and defining “required contribution” to be the price for the lowest price Bronze plan on the exchange, net of the subsidy that the individual would be eligible for through the Exchange). It is worth noting that the 8% threshold for the mandate is computed based on the lowest priced Bronze plan while the subsidies are computed based on the second lowest priced Silver plan.

¹⁴⁷ In 2016 that threshold will be \$9350 for an individual and \$18,700 for a married couple filing jointly. Of note, the penalty is capped at the price of a Bronze plan on the Exchange. According to the Congressional Research Service, an individual Bronze plan will cost about \$4000 in 2016 and a family plan will cost about \$12,000. For an individual the cap is reached at about \$189,000 annual income and for a family at about \$480,000. Considering that only 5% of U.S. families made more than \$199,000 income in 2008, it seems quite unlikely that the caps will be reached very often. See U.S. Census Bureau, *Statistical Abstract of the United States: 2011* (130th Edition) Washington, DC, 2010; Table 694, Money Income of Families (2011), available at http://www.census.gov/compendia/statab/cats/income_expenditures_poverty_wealth.html.

individual making less than \$37,150.¹⁴⁸ The \$2085 minimum penalty for a family of four is more than the 2.5% penalty for any family of four making less than \$102,100.¹⁴⁹ Median U.S. family income in 2008 was \$40,466.¹⁵⁰ Even allowing for inflation in median income between now and 2016, this means that a large percentage of the people required to purchase insurance on the Exchange will face a net price of *less* than six percent of income.

Finally, if large numbers of middle income Americans are unwilling to spend six percent of family income on health insurance, the U.S. has a health care cost expectations problem that will require much more than a higher powered penalty to address. Americans who obtain their health insurance through work presently pay, on average, 8.6% of their gross income for that insurance.¹⁵¹ People cannot reasonably expect to pay less for comparable coverage through the Exchange. The Congressional Budget Office reports that most current employment plans are similar to the Silver plans that will be offered on the Exchange and, thus, more generous than the Bronze plans that I have been using for my calculations. Bronze plans are expected to cost about 25% less than Silver plans,¹⁵² so the six percent of income *maximum* net price seems more than fair.

2. THE EXCHANGES CAN TOLERATE NON-COMPLIANCE

Inevitably, some people will not participate on the Exchange even though they are supposed to. Economic theory suggests that, on average, the people who do not participate will be healthier than those who do.¹⁵³ There is some research suggesting that the extent of this adverse selection

¹⁴⁸ \$37,150 minus the single taxpayer filing threshold of \$9350 equals \$27,800. 2.5% of \$27,800 is \$695.

¹⁴⁹ \$102,100 minus the married filing jointly filing threshold of \$18,700 equals \$83,400. 2.5% of \$83,400 is \$2085.

¹⁵⁰ See U.S. Census Bureau, Statistical Abstract of the United States: 2011 (130th Edition) Washington, DC, 2010, Table 695, Money Income of Families.

¹⁵¹ See note __, *supra*.

¹⁵² See Letter from Congressional Budget Office to Senator Olympia Snow, Jan. 11, 2010, *available at* http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf. This letter reports:

CBO estimates that premiums for Bronze plans purchased individually in 2016 would probably average between \$4,500 and \$5,000 for single policies and between \$12,000 and \$12,500 for family policies. For comparison, the previous analysis of the PPACA as introduced found that average premiums among all types of plans in 2016 would be about \$5,800 for single policies and about \$15,200 for family policies. Average premiums for Bronze plans would be lower than average premiums for all plans because the actuarial value of Bronze plans would be 60 percent, compared with an estimated average actuarial value for all individually purchased plans of roughly 72 percent.

¹⁵³ See TAN __, *supra*.

will be less than theory predicts.¹⁵⁴ Nevertheless, for present purposes, I will assume the theoretical prediction to be borne out in practice. Will that make the Exchanges unsustainable?

This is a complicated question that requires empirical estimation to answer with precision, but it can be thought through in a rough way as follows.

First, raising the average risk level of people on the Exchange will not raise the maximum net price that any individual would be required to pay in order to avoid the penalty, nor will it raise the maximum net price that anyone with a family income of less than 400% of the Federal Poverty Level will have to pay in order to actually purchase health insurance on the Exchange. Those maximums are set by statute, not by the market, and they are designed so that most people buying insurance on the Exchange will not be paying the market price. Raising the average risk level increases the market price, not those statutory ceilings. Thus, the net price for most people will not change.

Second, raising the average risk level would increase the net price for higher income households, who are not eligible for the subsidies. By definition, those households are better able to afford a higher price. Significantly, those households are least likely to be buying insurance through the individual exchange, however, because they receive the most benefit from obtaining their health insurance through employment. (In other words, to get their health insurance subsidy, higher income people need to “buy” their insurance through work in the form of foregone wages.) The higher the price they face on the individual exchange, the more valuable their employee benefit income exclusion tax subsidy will be, and, therefore, the more likely they are to push to receive their health benefits through employment. In states that integrate the individual and small employment exchanges, those individuals may well obtain their insurance through the Exchange in either event. But, if only because of the difficulty of amending an employee benefit plan to eliminate health benefits, someone participating in the Exchange through employment is less likely to drop out of the Exchange when the price goes up.

Third, raising the average risk level might or might not increase the cost of the subsidies to the federal government. The answer to this question depends on the relationship between the penalties that the federal government collects, the subsidies that it would have paid to those who chose not to participate, and the additional subsidies it pays as a result of the increased average risk

¹⁵⁴ See Cohen & Siegelman, *supra* note __ at __.

level of those people purchasing on the exchange.¹⁵⁵ In any event, as long as the federal government is able to pay the increase (if any) in subsidies, the sustainability of the Exchanges will not be affected.

Obviously, this mental exercise does not prove that the Exchanges can tolerate significant non-compliance. Combined with the preceding discussion of the penalties, however, I see cause for optimism, while recognizing the need for a more systematic empirical estimation of the impact of non-compliance on the Exchanges.

CONCLUSION: THE MORAL OPPORTUNITY OF INSURANCE

Political scientist Deborah Stone has long argued for understanding insurance in political terms, not simply as an institution that modifies individual incentives.¹⁵⁶ As she explains, bringing a sphere of human activity into the insurance field necessarily begins (or continues) moral and political conversation:

Political science offers a very different interpretation of the steady, long term growth of insurance in modern industrial societies. Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation. Insurance influences how individuals behave, not so much by dangling incentives in front of them one by one, but rather by offering arenas for collective moral deliberation and political action.¹⁵⁷

In the case of health care, the moral and political conversation about risk and responsibility has long been underway. The Affordable Care Act reflects and contributes to that conversation, but it makes no radical changes. The concept of the deserving poor disappeared from national Medicaid standards, but that was an incremental step and hard to avoid under any approach to universal coverage. Ability to pay will matter somewhat more than in the past, but how could it not

¹⁵⁵ The underlying intuition can be seen by thinking about the following (obviously not serious) suggestion: if the federal government really wants to save money under the Affordable Care Act, it should pay low income people to flout the mandate, and it should pay low income, high risk people serious money to relocate permanently to Mexico.

¹⁵⁶ Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in Baker & Simon, *supra* note __ at 52 (also published in 6 CONN. INS. L. J. 11).

¹⁵⁷ *Id.* at 74.

in the face of rising health care costs and following a period of such increase in financial inequality? The individual and small group market will be remade, but not out of whole cloth. There are signs pointing toward a new responsibility to be as healthy as you can, but those signs appear alongside many others enlisting individual responsibility in support of a greater good. What that greater good is – or should be – will remain a matter of debate. As I hope this essay has demonstrated, health insurance will be one important arena in which that debate will take place.