Published in issue 124 of the Journal of the British Insurance Law Association

U.S. Healthcare Reform 2010-2011

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1. Introduction

In 1932, the number one song on the U.S. hit parade was "Brother, Can You Spare a Dime?"[3] It expressed the bafflement of millions of American workers who had built the great infrastructures of the 1920s, only to find themselves standing on bread lines in the 1930s.

That song could be a perfect anthem for the healthcare crisis in the United States today. Once perceived as the greatest healthcare delivery system in the world, U.S. health care proceeded to, as Milton put it, "stumble on and deeper fall," with between 50 to 85 million uninsured people straining the system and causing ever-increasing losses.[4] A recent analysis of the U.S. healthcare system reported that the U.S. spent twice as much as other industrial countries on healthcare but ranked *last* out of 16 industrialized countries in medical care mortality.[5]

The "Affordable Care Act"[6] is the Obama administration's comprehensive attempt to reform the private healthcare industry, improve medical care and halt catastrophic financial losses. The Act is highly controversial. Its opponents believe it not only violates the Constitution but also imposes intolerable costs on the U.S. economy. Its proponents argue that the cost is already being borne by the U.S. economy, but in an economically unplanned and uncontrolled way.

The Act raises literally dozens of legal issues. In this paper, we provide a summary of the key elements.

2. Background to Reform

A few quick historical facts about U.S. health coverage. Almost 100 years ago, in his 1912 presidential campaign, Theodore Roosevelt first raised universal healthcare as a national goal. But nothing more happened until 1945, when Harry Truman made a very committed effort to pass healthcare legislation. He failed in the face of exactly the same type of ideological opposition that the 2010 legislation faced: charges that the legislation was "socialist."[7] In 1965, Lyndon Johnson succeeded in introducing his "Great Society" programs that included Medicare and Medicaid (programs for medical care based on age or low-income levels). At the signing ceremony, Johnson issued the very first Medicare card to Harry Truman, who attended.[8]

But Medicare and Medicaid are limited coverage programs. The next attempt to pass universal health legislation took place in 1992-1994 with Bill Clinton. But that effort backfired amid charges that Hillary Clinton, who was unelected and unaccountable to

anyone except her husband, tried to develop a comprehensive health reform plan in secret sessions.[9] Public fury, generated by what was characterized as "Star Chamber" action on a topic of tremendous public interest, essentially killed healthcare reform for almost 20 years.

Today, employer-provided, private group health coverage is the backbone of the U.S. healthcare delivery system. Nearly 55% of the population is enrolled in these plans.[10] Medicare and Medicaid, with coverage for the very poor and the elderly, adds coverage for about 30%.[11] But there still remains a 16% gap in coverage among the jobless, self-employed, part-time employed, and employees of small business, who make up the 50 to 85 million uninsureds.[12] Obviously, many uninsureds *do* get minimum essential medical treatment because virtually all hospitals are required to provide emergency services without regard to ability to pay.[13] The real question is how to pay for this treatment.

By the time of President Obama's election in 2008, the healthcare had already become a heavy burden on the U.S. economy. In 2008, uninsured Americans consumed $116 billion of healthcare services. Those massive losses were transferred to insured Americans. Ongoing job layoffs throughout the economy ended employer-provided group coverage for millions of people. This inflated the already large ranks of uninsureds. Some companies dropped health coverage for employees.[14] Finally, the lack of jobs for newly-graduated students meant that they had no access to employer-sponsored group coverage. They too were added to the uninsured population.

The unemployed, self-employed, and small business employees remain the groups that do not qualify for large group health plans and are most likely to be uninsured or inadequately insured. The only alternative for them — private health plans for individuals or small businesses — remains vastly more expensive than large group coverage, has higher deductibles, excludes pre-existing conditions, and offers lower benefits, leaving millions without comprehensive insurance. The result is that hospital emergency rooms are increasingly packed with uninsureds seeking subsidized health care, subverting the real purpose of emergency care facilities, and driving up medical costs for everyone else.

Today, U.S. health care accounts for 17% of the GDP, estimated to become 20% by 2020. From 2001 to 2007, healthcare costs reportedly rose four times faster than wages.[15] In the 10 years from 2001 to 2011, healthcare costs for a family more than doubled, from $7,061 to $15,073,[16] and is projected to reach $32,175 by 2021.[17] In 2011, an economically stagnant year, the cost of health insurance still rose 9%.[18] More employers are shifting a greater proportion of the costs to their employees.[19] And, in the last year alone, 9% of employers dropped medical coverage for their employees.[20]

3. The Affordable Care Act

These are the facts used to justify healthcare reform. Opponents of reform claim the country cannot afford the cost. Proponents of reform claim the country is already paying through *de facto* cost-shifting.

In March 2010, the Obama administration succeeded in enacting the 975-page "Affordable Care Act." Its short-term purpose is to extend health coverage to those not covered by private health plans, Medicare, or Medicaid. This essentially means the self-employed, part-time employed, small business employees, and the unemployed. Its long-term goal is to impose premium-containment measures and quality standards on all U.S. health care by 2018.

Congressional voting on the Act was fiercely partisan. Not a single Republican supported it in either the Senate or the House. House Republicans are publicly committed to its repeal. Some Republicans charged that the legislation would lead to "death panels" that would deny medical funding for the sick and elderly. "Obamacare" became a pejorative term.[21] On November 9, 2011, 61% of Ohio voters repudiated mandatory healthcare.[22] There are at least 28 private or government lawsuits that challenge the law. Republican governments of 26 states have jointly challenged the Act's constitutionality, and the Supreme Court of the United States will probably decide that case by June 2012 (see section 8).

4. U.S. Health Care: A Patchwork Blend of Private and Government Responsibilities

Unlike the British or Canadian single-payor systems, U.S. healthcare responsibilities have always been inefficiently and ineffectively divided among the private sector, federal, and state governments.

Today, the federal government funds Medicare (the older-age medical program). Federal and state governments, and in some cases, counties, fund Medicaid (the low-income medical program). States administer Medicaid. And, for those who are not familiar with U.S. practice, insurance is separately regulated in 51 independent jurisdictions (50 states plus the District of Columbia). Most states traditionally exerted little power over rates.

Healthcare reform increases the already great complexity of these overlapping responsibilities. The private sector will continue to deliver almost all healthcare coverage (since the proposed, government-run "public option" was killed by the Senate Finance Committee). Starting in 2014, virtually every uninsured person will be required by federal law to buy private health insurance. The overwhelming proportion of them will buy insurance on exchanges run by the states, according to federal standards, initially funded by federal money, subject to rigorous federal and state rate-regulation, and with the right of federal preemption if the state does not carry out its responsibilities. In this context, federal preemption means that the federal government will displace the state, establish the state exchange itself, and then run it according to federal standards. Even states that oppose the Act and have sued to stop it do not want the federal government operating their exchanges.

The Act is designed to work within this patchwork through four major reform initiatives:

First, the Act expands Medicaid coverage for low-income insureds, and provides sliding scale subsidies for moderate income individuals and families .To enhance the affordability of coverage, the Act requires states to set up state or regional "exchanges" or information/marketplaces, and directs the federal government to run exchanges if a state does not organize one. Individuals and small businesses can use the exchanges to compare and buy comprehensive and "approved" private health plans from "certified" vendors. (Those with large group coverage cannot buy from the exchanges until 2017.)

Second, the Act requires every uninsured person (including individuals, small business employees, and the jobless) to buy private medical coverage — or risk a fine if they don't. This controversial part of the Act has led to major Constitutional challenges (please see section 8).

Third, the Act imposes minimum standards on all health plans, including traditional employer-paid health plans. Some of these changes, like exclusion of pre-existing conditions or elimination of lifetime limits, take effect right away.

Fourth, the Act and related legislation has extensive and radical premium-containment provisions. One change with immediate effect is the imposition of "medical loss ratios" (discussed in section 7). One writer likened these to utility regulation.

Let's look at each of these in turn.

5. The "Insurance Exchange": a New Information Center and Marketplace

The new "Affordable Insurance Exchanges," to be phased in by 2014, are a key feature of the legislation. Private plans for individuals and small groups will be marketed through state-controllled exchanges, all subject to federal and state quality and premium-containment review. In government terms, the exchanges will replace the current "dysfunctional" market for individual and small business coverage with one that is efficient and "transparent."[23]

The goal of the electronic "marketplaces" is to increase head-to-head competition in the sale of private health plans to individuals and small businesses. This is meant to lower prices and enhance quality. To enhance competition, insurers who want to sell on the exchanges must describe their plans in plain English and must use a standard template and fixed terms (like "deductibles" and "co-payments") so that people can see how health plans differ on an "apples-to-apples" basis.[24] To compete on an exchange, all health plans must meet minimum federal standards, and all insurers must be certified.

The exchanges will also let consumers see if they qualify for Medicare, Medicaid, or government subsidies, and then let them buy coverage through the exchanges if they need it.[25]

The idea of exchanges is not new in the U.S. California tried a health exchange in 1992, followed by Texas, Florida and North Carolina.[26] All of them failed. Allegedly, private

insurers had "cherry picked" the small businesses with healthy employees and left a pool of expensive insureds in the public exchange.

On the other hand, Massachusetts started its exchange in 2006, when it also introduced an individual mandate and prohibited insurers from excluding applicants. As a result of these reforms and related measures, the state achieved a 98.1% coverage rate. The Massachusetts exchange is the general model for the federal program. Under the new federal law, insurers are not allowed to refuse to cover pre-existing medical conditions. This in theory will put each private insurer in the same competitive position, with the identical risk pool.

There is no one model for exchanges. Individual states (or groups of states) must establish and run the exchanges according to minimum federal standards. But they can be flexible in how they set up their exchanges.

The federal government has already committed close to $300 million to the states to develop exchanges, including the complex IT systems they require. So far, it has granted close to $220 million.[27] If a state exchange does not meet federal standards by 2014, the federal government will step in, take it over, and run it.

The Act also offers "Early Innovator" awards to induce states to develop systems that can be adopted by other exchanges. The federal government has already awarded $155 million under this program.[28] But politics intervened in the exchange rollout. Kansas, for example, received a special $31.5 million grant to develop an IT infrastructure that was to have been shared with other exchanges. But then, in a controversial move, Kansas abandoned the project and returned the money, allegedly at the behest of state Republicans.[29] Oklahoma returned a $54.6 million grant for the same reason.[30] Both states are plaintiffs in a lawsuit challenging the constitutionality of the Affordable Care Act. This is a graphic reminder of how U.S. healthcare reform treads heavily on sensitive ideological feet.

6. The "Individual Mandate" Requirement

The "individual mandate," or mandatory purchase requirement, requires almost everyone without health insurance to sign up for a private health plan. (For those who can't afford it, there will be graduated subsidies available for up to 400% of the federal poverty level). 26 states are challenging this provision as an unconstitutional extension of the Commerce Clause (please see section 8).

The "individual mandate" was driven by underwriting economics. The key to lower rates is the ability to spread risk and include as many low-risk members as possible in the insurable pool. This overcomes the "adverse selection" phenomenon: as one witness observed during the Congressional hearings on the Act, the "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital."[31] In fact, about 30% of those aged 20-29 go without health insurance, even when it is available through their employers, because it is too expensive. But they are the group whose premiums, good health, and low incidence claims are needed to support the

system. The new Act tries to prevent this "free rider" approach. To prompt the young and healthy to buy insurance (and expand the risk pool), the Act uses penalties, assessed by the IRS as part of the tax process. For constitutional reasons, to invoke the "taxing power" of the federal government, these penalties are called "taxes."

But whatever the name, this structure raises two strategic questions. *First*, if people are near the poverty level with only limited resources, will they really spend their money on a private health plan instead of food? These, of course, are the people who don't file tax returns and therefore won't be "taxed" by the IRS for their failure to buy insurance. In fact, the Senate Finance Committee recently announced that 51% of U.S. households pay no federal income taxes.[32]

Second, even when the uninsureds can afford to buy insurance (for example, young people starting to work), are the fines set high enough to pressure them to buy? The only penalty is a fine (there are no criminal sanctions or liens). But the penalty that starts in 2014 is only the greater of $95 or 1% of income, and rises in 2016 to $695 or 2.5% of income. For some, the health plans cost *more* than the fines. Will this work?

And there always remains the ultimate question: will people who stubbornly refuse to buy insurance ever actually be denied medical care if they really need it? Most people bet not, especially since laws require most hospitals to provide at least emergency treatment without regard to ability to pay. If they're right, that undermines the entire economic theory of the Act.

On this issue, some point to the success of the Massachusetts health care model. In 2006, long before federal healthcare reform, Massachusetts independently set up a system that incorporated most of what became federal features. There is an exchange model where seven different health carriers offer coverage for individuals and small business. There is a mandatory purchase requirement, together with low-income subsidies for those who need a financial assist, and penalties for those who do not enroll. The state now boasts that 98.1% of its residents are insured.[33] On the other hand, health insurance costs in Massachusetts are growing at a faster rate than anywhere else in the country, and a rate that is largely seen as far higher than anticipated when Massachusetts enacted its reform law in 2006.[34]

7. Mandatory Changes to Health Plans

The new Act requires states to expand their Medicaid coverage for those with low-incomes. It also requires that every health plan issued after September 23, 2010 provide coverage in 10 defined categories of care. ("Grandfathered" plans are excluded). However, in December 2011, the federal Department of Health and Human Services announced that they intended to allow the individual states to select the types of minimum benefits for each category of care.[35] This surprised many observers, who had believed that there was going to be a national standard for healthcare.

Generally, the most important features of medical reform are:

- Elimination of lifetime or annual limits on health care.
- Mandatory coverage programs for those with pre-existing conditions.
- Children up to 26 years can already stay on their parents' health plans.
- Elimination of an insurer's right to cancel a policy except in the case of *relevant* fraud.
- 100% coverage of preventive services.
- The Act also imposes general infrastructure changes to help reduce long-term healthcare costs. For example, it imposes electronic health information standards to eliminate paperwork. The government estimates this change alone would save as much as $12 billion.
- These enhanced health benefits will be funded by a variety of tax increases, including upper income payroll taxes, taxes on brand-name drugs, and taxes on seemingly random taxable targets (including tanning salons, and a 3.8% real estate transfer tax regardless of whether there was a profit or not). Finally, the Act will also impose a 40% tax on high-cost health insurance policies (above $10,200 for individual coverage and $27,500 for family coverage). These are typically high-benefit, low-deductible plans offered to senior executives of large corporations, and are widely known as "Cadillac" plans, named after the American luxury automobile. These types of taxes have provoked charges that "Obamacare" is creating class hatred.

There is major debate over the economic impact of the legislation. The Congressional Budget Office claimed that the Act would *reduce* the federal deficit by $143 billion over ten years.[36] The Republican House Budget Committee claimed it would *increase* the deficit by $700 billion over the same time, and also kill 1.6 million jobs.[37]

8. The Premium-Containment Provisions

The new federal law contains premium-containment provisions that apply to health plans. At the same time, the federal Department of Health and Human Services also encourages states to amend their insurance laws to give insurance regulators more control over *all* healthcare plans, including the large group plans that were not the real target of this legislation.

These provisions are often described as "cost containment." In fact they do not change many of the problems that have driven up healthcare costs. For example, they do not deal with tort reform or put any cap on pain and suffering, both factors that have driven up the cost of malpractice insurance and have prompted what some people think are really "defensive" rather than necessary medical tests.

Here are some of the key features:

First, the federal law imposes new medical loss-ratio reviews. The federal Department of Health and Human Services has set minimum "medical loss ratios" (meaning the part of the premium that must be spent on health services and not on administrative costs or profits). For individuals and small group plans, the rate is 80%; for larger groups, 85%.

Historically, medical loss ratios for individual and small business markets have ranged from 55% to 80% in recent years.[38] Insurers that don't meet these new standards will be forced to rebate part of the premiums they collected.

One commentator observed:

> "this law involves substantial regulation of the health insurance industry that rises to the level of systematic coercion. The control that the United States Legislature exerts over the insurance industry through PPACA is tantamount to that of a public utility."[39]

The reference to public utilities is exactly right. Insurers will now need to justify their annual rate increases above 10% through very extensive rate-making examinations and public hearings, both typically subject to political pressure, as has the property and casualty segment of the insurance industry.

The National Association of Insurance Commissioners developed this formula for calculating medical loss ratios:

MEDICAL LOSS RATIO =
(claims + activities to improve health care quality)/
(premiums – total federal income taxes – state premium taxes and assessments + federal income tax on investment income).[40]

Even the secretary of the National Association of Insurance Commissioners has admitted that "loss ratios in the health field are especially complicated . . . . Companies use so many tools to manage care, and classification is not easy."[41] This is a potential area for litigation.

Some critics see this combination of "competitive" exchanges and rate regulation as an economic anomaly. The general theory of service-industry regulation is that the government grants a monopoly in exchange for the right to restrict prices to a "reasonable return." Here, the exchanges are supposed to be competitive markets and there is no contemplation of any monopoly. But the "competitors" are still subject to rate control.

Second, the law imposes a requirement for insurers to publish and justify healthcare rates. From September 1, 2011, insurers asking for 10% or larger increases (on non-grandfathered plans) must disclose the reason for them. (In 2012, the 10% will change to state-specific limits.) States that have the ability to perform effective rate reviews will conduct them. For states that don't, the federal Department of Health and Human Services will conduct the rate reviews. These rate justification provisions allow states to compare an insurer's rate increases on an exchange with its rate increases elsewhere. From 2014, states can exclude high-increase insurers from their exchanges unless the rates can be defended. Although 10% may sound like a large increase, healthcare costs have been rising at about

8% annually. As a result, this provision will put many insurers in the position of seeming to justify high rates when their own margins may be small.

Third, the law eliminates most traditional healthcare underwriting criteria (such as existing medical conditions). It will allow health insurers to consider only four factors: (1) the type of plan being offered (family or individual plan), (2) the geographical area, (3) age, and (4) tobacco use. Insurers will be forbidden to consider traditional underwriting elements such as "health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury . . . or any other health status-related factor determined by the Secretary [of Health and Human Services]."[42]

Fourth, the federal Department of Health and Human Services encourages individual states to amend their insurance laws and exert greater control over all healthcare rate increases, not just the plans to be sold on the exchanges. The federal government has allocated $250 million to help states increase their ability to review rate increases. Many states have already increased their power to review rates and some states have used federal funding to enlarge their staff and hire more specialized actuaries. Since the provisions became effective, there have been several cases where insurers backed down from dramatic rate increases in the face of state challenges.[43]

Fifth, while insurers will have to justify increases greater than 10% on the exchanges, even smaller increases can be and have been challenged under existing state insurance law.[44] As we mentioned, each of the states has its own insurance laws, some of which differ substantially. Some states already empower their insurance departments to review and approve healthcare rate increases *before* they become effective.

One carefully-watched proceeding of this sort is unfolding in Maine, a prior approval state. There, the regulator must decide that proposed rates are "adequate" but not "excessive." Based on this power, the regulator cut back a proposed rate increase from 18.5% (with a profit margin of 3%) to 10.9% (with a 0% profit margin) for one year and allowed small increases for later years. The regulator considered the insurer's historic profits in the state as well as its company-wide reserves. The regulator also concluded that its economic analysis did *not* need to be restricted to the product line being approved. The insurer sued, claiming that the decision violated the Due Process and Taking clauses of the Constitution.[45] The case is on appeal to the state's highest court and has received national attention because of its precedential value.

One aspect in this case is of particular interest because it will doubtless feature in the many rate-making cases to come. Maine allows the public, as well as consumer advocates, to appear and "testify" at rate-approval hearings, even though their "testimony" may be unsworn. (The expenses of the consumer advocates are, by regulation, paid by the insurer.) Consumer "testimony" in rate-making proceedings has been a traditional American populist practice over the years. Some highly-controversial utility hearings of the 1970s

took on the characteristic of revival meetings, with public prayers for low rates literally offered as the hearings began. The public appears to believe that if members can "testify," their testimony must have some effect. In the Maine proceeding, the hearing officer claims not to have considered the unsworn statements. Whether they should have been taken at all is an issue to be dealt with by the next level of appeals court.

9. Other Major Medical Industry Changes

Aside from rate-making issues, other containment changes in the Affordable Care Act include:

- For federally-funded programs, physicians and hospitals will now be paid on *value-based* standards, not on individual tests and procedures. The federal government will have the power to change "misvalued" fees and to impose fines for waste such as hospital-acquired infections and unnecessary readmissions.
- New "accountable care organizations" will allow physicians and hospitals to coordinate care and reward them with a share of any savings if the actual cost is less than projected.
- New pilot programs will be developed to encourage all healthcare professionals to achieve savings through *result-oriented* care, as opposed to less inefficient, "fee-for-separate-service" care.
- There will be increased funding for fraud control.
- More money will be earmarked for preventive medicine.
- An Independent Medicare Advisory Board will set treatment standards and costs not only for Medicare spending but also private medical coverage. This suggests that there will be a single medical-practice standard for all treatment regardless of the payor or the patient. This Board's recommendations will become law unless overridden by new legislation.
- New "CO-OPs" (Consumer Operated and Oriented Plans) that are designed to establish non-profit, consumer-managed insurers in each state. The federal government will spend close to $4 billion on start-up or operating loans to establish these CO-OPs.

10. Constitutional Challenges

At least 24 lawsuits, including 28 state governments as plaintiffs, have challenged the constitutionality of the Affordable Care Act. As we already mentioned, private insurers are separately challenging the right of state regulators to limit rate increases. There are also private actions to declare the Act unconstitutional. One case challenged the Act because it was signed by a President who was not a "natural born citizen."[46] Another case, recently dismissed, charged that the Act violated religious freedoms.[47]

The state government challenges essentially claim that the Act violates the sovereignty of the individual states, mainly on the ground that it tries to regulate purely *state* commerce,

as opposed to *interstate* commerce. One state attorney general explained that the Act is "an assault against the Constitution," and that "a legal challenge . . . appears to be the only hope of protecting the American people from this unprecedented attack on our system of government."[48]

Of all these cases, the most important is *United States Department of Health and Human Services v. State of Florida*, 648 F.3d 1235 (11th Cir. 2011), a case that pits 26 states against the federal government in a lawsuit that began literally minutes after the passage of the Act.

The main legal issue on this appeal involves the "individual mandate" provision and its relationship to the Commerce Clause of the U.S. Constitution. Under Article I, §8, Cl. 3, Congress has the power to "regulate Commerce . . . among the several States." That provision was narrowly interpreted in the late 18th and early 19th century. As industrialization increased, the Supreme Court expanded the interpretation of these powers, which now extend to the regulation of "purely local" *intra*state conduct that has a "substantial *effect* on interstate commerce." *Gonzales v. Raich,* 545 U.S. 1, 17 (2005). This was the constitutional basis on which the Obama administration justified the powers of the Affordable Care Act. The administration argues that the Act does not challenge the "sovereignty" of the states but rather regulates private conduct that *affects* interstate commerce.

In January 2011, a U.S. district court found that the "individual mandate" was an unconstitutional reach of the Commerce Clause, could not be severed from the rest of the legislation, and that therefore the entire Act was invalid.[49] On appeal, by a 2-to-1 vote in August, the U.S. Court of Appeals for the Eleventh Circuit affirmed that the Act was unconstitutional.[50] But it concluded that the unconstitutional parts (like the "individual mandate") could be severed and the rest of the Act upheld.

As we saw, the economic basis of the entire legislation is that mandatory coverage is necessary to enlarge the risk pool and offer an inducement to private insurers. The majority of the 11th Circuit (which covers Florida) rejected this argument, concluding that the "individual mandate" provision is invalid because it compels economic action from people who may not need health care for years (and who, presumably, do not yet affect interstate commerce). The dissent argued that the cost-shifting caused by uninsureds already affects interstate commerce.

As a separate matter, the majority also held that the penalty provision for those who do not buy insurance is illegal because it is not a proper exercise of Congress' taxing power under Article I of the Constitution. They held that it is a fine, not a true tax.

On November 14, 2011, the Supreme Court agreed to review the case.[51] It scheduled 5 ½ hours of oral argument for March 2012 (the longest time allotment since 1955). The decision should be published by June 2012. The three questions the Court will consider are (1) whether the "individual mandate" requirement is unconstitutional; (2) whether the provision is severable; (3) whether the federal government can force the states to expand Medicaid coverage; and (4) whether the tax penalty can be challenged at all until 2015, when it actually takes effect.

11. The Prognosis

Some dramatic change is needed to deal with the relentless rise in healthcare costs, with the overall ineffectiveness of the system measured by health outcome, and with the 50 to 85 million uninsureds. The federal government has already spent billions to implement the 2010 Affordable Care Act. But the form of the outcome is not necessarily fixed. Constitutional challenges, as well as Republican vows to repeal the Act, mean that this may not be the final salve for the country's healthcare woes.

Endnotes

[1] Alice Kane is a partner in Dewey & LeBoeuf LLP and leads the Health Insurance Practice. She was General Counsel of New York Life and Zurich Financial Services, Executive Vice President in charge of Asset Management at New York Life, and both President of the Mutual Fund business of American General as well as Executive Vice President in Asset Management.

[2] Steven Levitsky is an antitrust and regulatory lawyer at Dewey & LeBoeuf, and a member of the Health Insurance Practice. He is co-author of BNA's Antitrust Compliance Portfolio/M&A Portfolio, and has handled domestic and international antitrust clearances for some of the largest insurance transactions in history.

[3] Written by "Yip" Harburg and Jay Gorney, "Brother, Can You Spare a Dime?" was recorded by Bing Crosby and Rudy Vallee. Each version topped the charts. One verse of the song reads:

> Once I built a railroad, I made it run, made it race against time.
> Once I built a railroad; now it's done. Brother, can you spare a dime?
> Once I built a tower, up to the sun, brick, and rivet, and lime;
> Once I built a tower, now it's done. Brother, can you spare a dime?

[4] The U.S. Census reported that 46.3 million were uninsured in 2008, rising to 50.6 million in 2009. *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, p. 23 (U.S. Dept. of Commerce, September 2010). According to *Americans at Risk*, p. 2, a March 2009 report prepared by Families USA, in 2007-2008, at least 86.7 million people under 65 went without health coverage for at least some period in 2007-2008, and at least 51 million went without health insurance for more than nine months.

[5] *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*, The Commonwealth Fund Commission on a High Performance Health System, October 2011, pp. 9, 24-25. available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Oct/1500_WNTB_Natl_Scorecard_2011_web.pdf

[6] Passed March 23, 2010, its full name is the Patient Protection and Affordable Care Act.

[7] On November 19, 1945, President Truman sent a message to Congress that began:

> In my message to the Congress of September 6, 1945, there were enumerated in a proposed Economic Bill of Rights certain rights which ought to be assured to every American citizen.
>
> One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the

> "right to adequate protection from the economic fears of . . . sickness . . . ."
>
> Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

http://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1=. The American Medical Association attacked the bill as "socialized medicine" and attacked Truman's White House staff as "followers of the Moscow party line." Monte M. Poen, "National Health Insurance," in Richard S. Kirkendall (ed.), *The Harry S. Truman Encyclopedia* (Boston: G.K. Hall & Co, 1989), p. 251.

[8] http://www.ssa.gov/history/lbjsm.html

[9] *The New York Times*, March 5, 1993, described the task force meetings as "the unusual and highly secretive decision-making process devised by the White House for what is likely to be the costliest, most ambitious initiative in domestic policy since the New Deal."

[10] *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, Table 10, p. 29 (U.S. Dept. of Commerce, September 2010).

[11] http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/table10.pdf

[12] http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/table8.pdf

[13] Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.§ 1395DD(a)-(b).

[14] "Wal-Mart Cuts Some Health Care Benefits," *The New York Times,* October 20, 2011. The article reports that Wal-Mart cut off all coverage for employees who work less than 24 hours a week, and spouse coverage for employees who work less than 24 to 33 hours a week.

[15] According to a Kaiser Family Foundation study, "premiums for family coverage have increased 78%, while wages have risen 19% and prices have risen 17%." http://www.kff.org/insurance/ehbs091107nr.cfm

[16] "Health Insurance Costs Rising Sharply This Year, Study Shows," *The New York Times*, September 27, 2011.

[17] "Health-Benefit Costs Increase The Most in Six Years, Surpassing $15,000," *Bloomberg News*, September 27, 2011. http://mobile.bloomberg.com/news/2011-09-27/health-benefit-costs-rise-most-in-six-years-surpassing-15-000-per-family

[18] *The New York Times,* September 27, 2011. http://www.nytimes.com/2011/09/28/business/health-insurance-costs-rise-sharply-this-year-study-shows.html?pagewanted=all

[19] http://insight.milliman.com/article.php?cntid=7628

[20] http://www.bloomberg.com/news/2011-09-27/health-benefit-costs-rise-most-in-six-years-surpassing-15-000-per-family.html

[21] However, President Obama appears to have embraced it, saying, "I have no problem with people saying Obama cares. I do care." Reported by CBS News at http://www.cbsnews.com/8301-503544_162-20092578-503544.html

[22] "Ohio Vote on Labor Is Parsed for Omens," *The New York Times*, November 9, 2011. http://www.nytimes.com/2011/11/10/us/politics/ohio-vote-on-collective-bargaining-is-parsed-for-2012-omens.html?_r=1&scp=2&sq=ohio%20health%20referendum&st=cse

[23] http://docs.house.gov/energycommerce/cost_containment.pdf

[24] These descriptive labels include "What is the premium?", "Are there other deductibles . . . ?", "Are there services this plan doesn't cover?" The government's template for the disclosure of standardized terms appears at http://www.healthcare.gov/news/factsheets/2011/08/labels08172011b.pdf

[25] In a June 2, 2009 letter to the dying Senator Edward Kennedy (who had made universal health care one of his primary goals in life), President Obama wrote that the purpose of the exchanges was to create "...a market where Americans can one-stop shop for a health care plan, compare benefits and prices, and choose the plan that's best for them, in the same way that Members of Congress and their families can." http://my.barackobama.com/page/community/post/obamaforamerica/gGGGpK

[26] Cappy McGarr, "A Texas-Sized Health Care Failure," *The New York Times* op ed page, October 5, 2009. McGarr was chairman of the Texas Insurance Purchasing Alliance from 1993 to 1995. For the California experiment, see Jill Mathews Yegian, Thomas C. Buchmueller, Mark D. Smith, and Ann F. Monroe, "The Health Insurance Plan of California: The First Five Years," *Health Affairs*, Vol. 19, No. 5, p. 158. The California exchange was renamed

[27] http://www.statehealthfacts.org/comparereport.jsp?rep=89&cat=17

[28] http://www.statehealthfacts.org/healthreformsource.jsp

[29] http://www.khi.org/news/2011/aug/09/kansas-rejects-315-million-insurance-exchange/

[30] http://www.ihealthbeat.org/articles/2011/4/15/oklahoma-to-return-early-innovator-grant-for-insurance-exchange.aspx

[31] Professor Mark Hall, "47 Million and Counting: Why the Health Care Marketplace Is Broken," Hearing before the Senate Committee on Finance,110th Cong., 2d Sess. 52 (2008).

[32] http://finance.senate.g.ov/newsroom/ranking/release/?id=e7723a9e-ed4a-4e10-af90-a56dfb0ccec5

[33] https://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef-6f47d7468a0c?fiShown=default

[34] http://www.kff.org/uninsured/upload/7777.pdf

[35] http://www.hhs.gov/news/press/2011pres/12/20111216c.html

[36] Cost Estimates for H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation), p 2. (available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf)

[37] "Obamacare: A Budget-Busting, Job-Killing Health Care Law," p. 2 (available on the website of

the Speaker of the House at http://www.speaker.gov/Blog/?postid=219114)

[38] http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf

[39] Rebecca J. Kopps, "Dead on Arrival: The Health Insurance Industry's Bleak Prognosis due to Unconstitutional Ratemaking in the Patient Protection and Affordable Care Act," *North Illinois University Law Review*, Volume 31, Issue 3 (Summer 2011), p. 577.

[40] http://www.naic.org/documents/ppaca_sub_draft_mlr_rebate_reg.pdf

[41] http://money.cnn.com/2010/05/25/news/companies/medical_loss_ratio/index.htm

[42] PPACA, §2705.

[43] http://www.healthcare.gov/news/factsheets/2011/05/ratereview05192011a.html

[44] This does not mean that a state must accept a 10% increase. For example, the Rhode Island insurance department recently reduced a proposed rate increase from 7.9% to 1.9%. http://www.pbn.com/BCBS-of-Rhode-Island-Direct-Pay-rate-increase-slashed-from-79-to-19,56172

[45] The Fifth Amendment, which applies to the States under the Fourteenth Amendment, provides that "No person shall . . . be deprived of . . . property, without due process of law; nor shall private property be taken for public use, without just compensation." As far as ratemaking standards, the Supreme Court has said: "The guiding principle has been that the constitution protects utilities from being limited to a charge for their property serving the public which is so 'unjust' as to be confiscatory." *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307 (1989).

[46] Section One of Article Two of the United States Constitution states that "No person except a natural born Citizen . . . shall be eligible to the Office of President;" *Purpura v. Sebelius*, (USDC, DNJ, Index # 10-4814 (GEB)) alleges, among other things, that the Affordable Care Act is unconstitutional because it was signed by a President who was not a "natural born citizen." Complaint, ¶¶53-61. The substance of this claim is that the President is a dual citizen, because his father was a British subject, and that the term "natural born citizen" (not defined in the Constitution) means someone both of whose parents were citizens.

[47] *Susan Seven-Sky v. Holder*, ___ F.3d ___ (D.C. Cir., November 8, 2011).

[48] Statement of South Carolina Attorney General Henry McMaster, March 22, 2010, quoted in *The Christian Science Monitor*. http://www.csmonitor.com/USA/Justice/2010/0322/Attorneys-general-in-11-states-poised-to-challenge-healthcare-bill

[49] A copy of the district court decision appears at http://www.politico.com/pdf/PPM153_vin.pdf

[50] A copy of the Court of Appeals decision appears at http://www.uscourts.gov/uscourts/courts/-ca11/201111021.pdf

[51] http://www.supremecourt.gov/orders/grantednotedlist.aspx?Filename=11grantednotedlist.html