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EVERYTHING'S BIGGER IN TEXAS: EXCEPT THE MEDMAL SETTLEMENTS

TOM BAKER, ERIC HELLAND, AND JONATHAN KLICK¹

Recent work using Texas closed claim data finds that physicians are rarely required to use personal assets in medical malpractice settlements even when plaintiffs secure judgments above the physician's insurance limits. In equilibrium, this should lead physicians to purchase less insurance. Qualitative research on the behavior of plaintiffs suggests that there is a norm under which plaintiffs agree not to pursue personal assets as long as defendants are not grossly underinsured. This norm operates as a soft constraint on physicians. All other things equal, while physicians want to lower their coverage, they do not want to violate the norm and trigger an attack on their personal assets. This constraint should be less effective when physicians have other ways to shield their assets, such as through large personal bankruptcy exemptions like those available in Texas. Settlement data from the National Practitioner Data Bank indicate that settlements in Texas are abnormally low, just as they are in other jurisdictions with unlimited homestead exemptions in bankruptcy. Consistent with theory, we find that more generous exemptions are also associated with lower insurance prices and lower levels of insurance coverage. These results suggest that the large "haircuts" and low insurance limits observed in the Texas data may be driven by Texas's generous bankruptcy provisions. At a minimum, Texas is not generally representative of other jurisdictions. This weakens the case for extrapolating conclusions from Texas data to other jurisdictions.

I. INTRODUCTION

Academic theory, conventional wisdom, and empirical reality are orthogonal to one another when it comes to medical malpractice. In first year law classes, we teach that tort law induces doctors to conform to the prevailing standard of care.² Political rhetoric focuses on medical

¹ The authors wish to thank Daniel Baltuch and Ben Pyle for research assistance and Bernie Black for comments on an earlier draft.

² See, e.g., Richard Epstein, CASES AND MATERIALS ON TORTS, 253-

malpractice criseses, doctor shortages, and the costs of defensive medicine.³ The data suggest that while medical malpractice law does little to properly incentivize doctors⁴ and is an expensive way to compensate victims⁵ on the whole, it adds relatively little to the aggregate cost of healthcare.⁶

A series of papers using fairly comprehensive⁷ data from the Texas Department of Insurance (TDI)⁸ on closed medical malpractice claims in the state⁹ adds another degree of separation between theory, public

242 (9th ed. 2008).

³ For a discussion of this rhetoric, see Tom Baker, *The Medical Malpractice Myth* (2005).

⁴ For a recent review of the evidence, see Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93, 95 - 100 (2011).

⁵ See David M. Studdert, et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2025 (2006) (reporting that in a random sample of 1,452 closed medical malpractice claims, payments to lawyers accounted for almost half of the expenditures); This number is in line with that reported by Patricia Danzon which compares it with an overhead figure for first party insurance closer to 10 percent. Patricia Danzon, *Liability for Medical Malpractice*, 1 HANDBOOK OF HEALTH ECON. 1339, 1369 (2000).

⁶ Even studies with the largest estimates place medical malpractice costs at less than 3 percent of total healthcare spending in the U.S. See e.g., Michelle M. Mello, et al., *National Costs of the Medical Liability System*, 29 HEALTH AFFAIRS 1569, 1569 (2010) (placing the share at 2.4 percent). See also, Darius Lakdawalla & Seth Seabury, *The Welfare Effects of Medical Malpractice Liability*, NAT'L BUREAU OF ECON. RES., Working Paper No. 15383 (2009) (using sophisticated techniques to account for the endogeneity between health care spending and medical malpractice and still finds that tort awards account for less than 5 percent of the growth in medical spending since 2000).

⁷ The primary limitation in the TDI data is that there is limited or no information on small claims. Claims involving payments up to \$10,000 (in nominal terms) are not individually reported, and claims involving payments between \$10,001 and \$24,999 do not require detailed information in the associated filing. For example, filings in the latter category contain no information on the underlying injury. For all observations, one significant problem with the TDI dataset is that it contains no information on physician specialty.

⁸ For annual descriptive reports of these data, see *Texas Liability Insurance Closed Claim Annual Reports*, TEX. DEP'T OF INS., <http://www.tdi.texas.gov/reports/report4.html> (last visited Sept. 24, 2015).

⁹ For details on this dataset, see Bernard Black, et al., *Stability Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988- 2002*, 2 J. EMP. LEG. STUD.

perception, and reality in this context. Given the ubiquity of non-risk-rated medical malpractice insurance,¹⁰ for liability to generate incentives for physician care, there must be a non-trivial possibility that liability can exceed insurance limits.¹¹ Physicians themselves appear to fear exposing their personal assets to medical malpractice liability.¹² Yet, if the Texas data are representative, physicians rarely pay anything above their insurance limits in settlements, even if a case generates a judgment that exceeds those limits.¹³ That is, plaintiff awards above insurance limits generally receive a “haircut” bringing them down to a level where a defendant doctor does not have to use any personal assets to satisfy the judgment.¹⁴

The Texas data present a puzzle. If the risk of an above limit payment is really so small, why do physicians worry about liability at all? What’s more, given that Texas has no regulation requiring a minimum level of medical malpractice insurance,¹⁵ why do physicians buy as much insurance as they do? In equilibrium, the fact that plaintiffs do not pursue personal assets to satisfy above limit judgments should lead physicians to

207 (2005).

¹⁰ For a discussion of this peculiarity, see Frank A. Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128 (1990).

¹¹ Physicians may be incentivized by reputational concerns that are affected by the litigation system even if they do not bear the direct costs of settlements and judgments. For some evidence of these reputational concerns, see Eric Helland & Gia Lee, *Bargaining in the Shadow of the Website: Disclosure’s Impact on Medical Malpractice Litigation*, 12 AM LAW ECON REV 423 (2010).

¹² Internet searches yield numerous business entities advertising asset protection services aimed at physicians, invoking fears regarding medical malpractice claims. For example, see Capital Asset, Inc., <http://www.bulletproofasset.com/physicians.htm> (accessed October 11, 2013). Another telling indicator of the demand for asset protection services among physicians is the existence of the book, now in its second edition, Robert J. Mintz, *ASSET PROTECTION FOR PHYSICIANS AND BUSINESS OWNERS* (2nd ed. 2010).

¹³ David A. Hyman, Bernard S. Black, & Charles Silver, *Settlement at Policy Limit and the Duty to Settle: Evidence from Texas*, 8 J. EMPIRICAL LEG. STUD. 48 (2011).

¹⁴ David A. Hyman, Bernard Black, Kathryn Zeiler, Charles Silver, & William M. Sage, *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003* 4 J. EMPIRICAL LEG. STUD. 3, 7 (2007).

¹⁵ While some states do have such regulations, Texas is not among them. See American Medical Association, *STATE LAWS MANDATING MINIMUM LEVEL OF PROFESSIONAL LIABILITY INSURANCE* (2012).

reduce their insurance coverage.

The Texas results, and the questions they raise, relate closely to earlier work done by Tom Baker on the topic of “blood money.”¹⁶ In that work, attorneys suggested that plaintiffs are reluctant to pursue a defendant’s personal assets (blood money) both because it is relatively difficult to get at personal assets and because of the view that it is unfair, except in certain circumstances, to go after those assets. One implication of these findings is that, all other things equal, the easier it is for a defendant to shield her assets, the less likely it is that a plaintiff will pursue blood money. Subsequent work on the blood money phenomenon claims that generous bankruptcy exemptions are among the most important impediments keeping plaintiffs from pursuing larger settlements.¹⁷

In this article, we pick up some of the open questions raised by the work on haircuts in the Texas medical malpractice data in light of the qualitative work on blood money. After reviewing both sets of literature in section 2, we provide a simple model of the equilibrium behavior of a physician in choosing her insurance level in light of these literatures in section 3. In section 4, we briefly describe the homestead exemptions that exist in each state. In section 5, we outline the empirical evidence that supports our model. In section 6, we show that settlements are systematically lower in states with more generous homestead exemptions using comprehensive data on medical malpractice payments from the National Practitioner Data Bank. To link this result to our model, we provide evidence from a nationally representative survey showing that medical malpractice insurance prices are systematically lower in states with more generous exemptions, consistent with a model where the demand for insurance declines when bankruptcy law provides an alternate vehicle for protecting assets. Lastly, we analyze insurance policies from a database of an insolvent insurer showing that doctors choose lower policy limits in states with more generous bankruptcy protections, further bolstering our basic claims. Section 7 discusses the robustness and limitations of our results, and section 8 concludes.

In addition to verifying the importance of bankruptcy protections to tort law in action, our results suggest that at least some of the findings of the papers using the Texas closed claim data may be specific to regimes with large bankruptcy exemptions like Texas. Given that, it may not be

¹⁶ Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 *LAW & SOC’Y REV.* 275 (2001).

¹⁷ Stephen G. Gilles, *The Judgment-Proof Society*, 63 *WASH. & LEE L. REV.* 603 (2006).

reasonable to expect that haircuts will be as common or as large in states where asset protection is more difficult given the propensity of doctors to buy more medical malpractice insurance coverage in such states. Even if doubts remain about causality in the relationship we study, it seems clear that something makes Texas peculiar,¹⁸ limiting the value of using the TDI data to draw conclusions about the state of medical malpractice liability more generally. Concerns about unobserved heterogeneity of this type should lead researchers to focus on datasets that allow for better research designs that exploit natural experiments and more cross-jurisdiction comparisons.¹⁹

II. BLOOD MONEY AND BANKRUPTCY

The research on blood money grew out of a qualitative study of personal injury lawyers in Florida and Connecticut conducted in the mid-1990s. First focused on the relationship between tort claims and liability insurance,²⁰ the study went on to explore the circumstances in which plaintiffs seek more than just insurance money from individual defendants. That question touched such an emotional chord among the lawyers that it became a central focus of the interviews, with plaintiffs' and defense lawyers alike distancing themselves from "what we call blood money, instead of insurance company money."²¹ The defense lawyers emphasized the extent to which they protected their clients from having to pay blood money. The plaintiffs' lawyers emphasized the extent to which they acculturated their clients to the strong norm that plaintiffs are supposed "to take it [money] from an insurance company as opposed to an individual."²²

In explaining this norm, the lawyers identified moral and practical considerations. Except in three kinds of circumstances to be explained shortly, going after "blood money" is ethically and morally problematic for

¹⁸ Texas is peculiar for many reasons. See, e.g., Barney Smith's Toilet Seat Art Museum, Roadside America, <http://www.roadsideamerica.com/story/6166>. We focus solely on those related to medical malpractice in this article.

¹⁹ See generally, Joshua Angrist and Jörn-Steffen Pischke, *The Credibility Revolution in Empirical Economics: How Better Research Design is Taking the Con out of Econometrics*, 24 J. ECON. PERSP., no. 2, 2010 at 3.

²⁰ Tom Baker, *Transforming Punishment into Compensation: In the Shadow of Punitive Damages*, 1998 WIS. L. REV. 211, 214 (1998).

²¹ Baker, *supra* note 16, at 281.

²² *Id.* at 283.

both plaintiffs and their lawyers.²³ In addition, the lawyers reported that there are serious practical hurdles: “it is easier to collect from an insurance company than it is to go against the individual and try to garnish wages, foreclose on a home, as well as other things that most people aren’t interested in doing, whereas the insurance companies, they’re like a bank.”²⁴

As the lawyers reported, the legal rule regarding the liability insurer’s “duty to settle” reinforces the practice of accepting the available insurance money in settlement of the claim.²⁵ This legal rule obligates an insurer to “to make reasonable settlement decisions that protect the insured from judgments in excess of the policy limits.”²⁶ An insurer that breaches this duty must pay the full amount of any resulting judgment, notwithstanding the fact that liability insurance policies place limits on the amounts that insurers are contractually obligated to pay. This insurance law rule and the practical difficulties of collecting significant amounts of money from individuals combine to create a very strong incentive for plaintiffs’ lawyers to settle even very serious liability claims for the insurance policy limits, sometimes with the hope that the insurance company will unreasonably refuse to accept the offer, thereby “setting up” the insurance company to pay much more money after trial.²⁷

With or without this hope, the lawyers report that the moral and practical considerations against blood money create such a strong social practice of accepting the available insurance money as payment in full that it takes a great deal of effort for a plaintiff to persuade a defense lawyer that she or he is actually serious about demanding the payment of blood money in an ordinary negligence case.²⁸ For most plaintiffs in most cases against ordinary middle class defendants, the choice is clear, as explained

²³ *Id.* at 284-85. Interesting, the few plaintiffs’ lawyers who actively resisted the no blood money norm (while acknowledging that it existed) pointed out that lawyers who refuse to go after blood money may well be violating their ethical obligation to serve as zealous advocates for their clients. *Id.* at 287.

²⁴ *Id.* at 285. *See also Id.* at 289 (an explanation of how going after blood money can be harder and take longer than just collecting from insurance company).

²⁵ *Id.* at 291-92.

²⁶ Principles of Liability Insurance Project (AM. LAW INST., Draft No. 3, 2012).

²⁷ Baker, *supra* note 16, at 293-94. *See also* David A. Hyman, Bernard S. Black & Charles Silver, *Settlement at Policy Limit and the Duty to Settle: Evidence from Texas*, 8 J. EMPIRICAL LEG. STUD. 48 (2011).

²⁸ Baker, *supra* note 16, at 291.

in the following statement from a plaintiffs' lawyer who reported that he had never collected blood money:

This woman is coming in tomorrow; she has to make the decision. Does she want to pursue this guy on a personal basis? It's not going to make any difference, because ... the guy who caused all this happened to be a teacher, an elementary musical [sic] teacher. Makes about \$45,000 a year; he's got three kids. He's got no equity in his house, and he's got an old car. If she pursues him, what's going to happen is, she'll get a judgment. It's going to be for a lot more than \$100,000, and he's going to go into bankruptcy. And when he goes into bankruptcy, he's going to keep his house, he's going to keep his car, and he's going to keep under the statute, \$15,000. You can't tap into his IRA, if he has one, his 401K if he's got one for school, for his group, his employment. So what advantage is there for the client to do that? Plus, she can get \$100,000 now, or she can wait four years and get \$100,000. So, for that reason I've never been in a situation where I've taken personal liability.²⁹

The lawyers reported three circumstances in which pursuing blood money is not a breach of the norm: when the defendant clearly deserves punishment,³⁰ when the plaintiff died or suffered various serious injuries and the defendant's conduct was more than merely negligent,³¹ and when

²⁹ *Id.* at 289.

³⁰ *Id.* at 298 ("Parents and relatives of people who are killed by drunk[en] drivers want blood. They really want blood. I forgot what question of yours initiated this, but in those cases, the clients themselves have an interest in gouging, to make the point to the person and to have the word get out, usually to other youths that 'Holy shit! Jones's father lost his house.'").

³¹ *Id.* at 299 ("Generally, ... tragic injuries. I'm thinking of one where a young kid was rendered a quadriplegic in a swimming pool accident, and the people were actually supervising a party, like a high school graduation party or such, and they were actually there and they were allowing drinking; kids got crazy as teenagers ..., and the poor youngster ended up in a wheelchair. And the homeowners coverage, I think, was \$300,000, which obviously didn't even touch the value of the case, and we did attach property there because the people ... insisted on it, and we did get the payment because it was a fairly nice house and there was a good amount of money there; but we generally, and maybe it's just a personal preference, but we don't like doing it.").

the defendant failed to purchase enough insurance.³² The latter circumstance is what we focus on in this quantitative research. It is an imprecise, presumably local, norm:

How much is enough? My interviews do not provide a clear answer, but they do provide a way to think about it. The minimum is whatever it takes to claim, credibly, that you have satisfied your moral obligation to insure. Ordinary people have an obligation to purchase insurance in ordinary amounts. Wealthy people have an obligation to purchase insurance in larger amounts.³³

In the years since this qualitative research was published, legal scholarship has advanced the understanding of the blood money story in two main ways. First, Steven Gilles took the main empirical insight of the blood money research, combined it with Lynn LoPucki's "death of liability" idea,³⁴ and advanced the thesis that, at least for ordinary middle class individuals, ours is a "Judgment-Proof Society."³⁵ A host of legal rules that protect middle class incomes and assets from execution combine to make liability insurance the only significant asset available to tort plaintiffs. Gilles' exhaustive march through these legal rules provided firmer ground for the earlier, admittedly impressionistic observation by Baker that "for claims against all but the wealthiest individuals and organizations, liability insurance is a *de facto* element of tort liability."³⁶

Second, the team working with the Texas medical malpractice

³² *Id.* at 297 ("If a lawyer or doctor chooses to go bare, which is an economic decision to put more money in their own pockets and not pay their premiums, then I probably would go after them because that's wrong, because they are now not protecting— it's now not just being negligent, they're making a conscious decision that if they screw up, they're not going to protect their client or their patient. And they did that so that they could make more money.").

³³ *Id.* at 296-97.

³⁴ Lynn M. LoPucki, *The Death of Liability*, 106 YALE L. J. 1 (1996).

³⁵ Gilles, *supra* note 17, at 607 ("This Article is about how our laws have made being judgment-proof the rule rather than the exception; about what this implies for the standard deterrence, corrective justice, and loss-spreading accounts of tort law; and about whether anything should be done to lower the legal barriers to enforcing and collecting tort judgments from individual tortfeasors").

³⁶ Tom Baker, *Liability Insurance as Tort Regulation: Six Ways that Liability Insurance Shapes Tort Law in Action*, *Tort Law and Liability Insurance* at 295 (Gerhard Wagner ed. 2005).

closed claim data has used those data to test the blood money hypothesis quantitatively. They analyzed whether doctors ever paid blood money in medical malpractice claims in Texas. Their answer – almost never, not even in cases with big jury verdicts – supported the qualitative research, with three interesting extensions.³⁷

First, because doctors have incomes that are well above middle class, the explanation for this result cannot rest entirely on the practical bankruptcy protection explanations provided by the Connecticut lawyers. (Gilles would point to trust law.³⁸ The Connecticut lawyers would claim that morality also plays a role.) Second, the Texas data also include payments made in cases that went to trial, allowing the researchers to report that doctors rarely paid blood money even after losing a big case at trial.³⁹ Heretofore the blood money story had focused exclusively on pre-trial settlements. The finding that doctors did not have to pay blood money even when the jury verdict greatly exceeded the medical malpractice insurance policy limit significantly strengthened the thesis of the original qualitative research. If doctors regularly make post-verdict settlements that give the plaintiffs only the insurance money, plaintiffs have little hope of collecting blood money from a pre-trial settlement.

This dynamic explains the third, initially surprising extension of the Texas researchers: Texas doctors buy insurance policies with much lower limits than scholars had previously believed, and the amount of insurance that the doctors bought declined in real terms over the years the researchers studied. Taking the blood money story seriously, however, this result is not surprising. Why should physicians buy more insurance than they need? Once doctors buy enough insurance to satisfy the “no blood money” norm and the liability insurance requirements of their contracting partners (most significantly, hospitals), any additional insurance provides a benefit only to patients who sue them. Within the dominant world view of the medical profession, patients who sue are the enemy, not a group deserving of extra protection from physicians’ voluntary purchase of

³⁷ See Hyman, *supra* note 13, at 48.

³⁸ Gilles, *supra* note 17, at 635-42.

³⁹ Hyman et al., *supra* note 13, at 51. See also, Hyman et al., *supra* note 14 at 7 (“Post-verdict settlements were often at or below policy limits even when the adjusted verdict exceeded these limits. In the 214 “single-payer” cases for which we have data on policy limits, we estimate that policy limits explain at least 73 percent of the aggregate haircut (\$71 million/\$97 million). In single-payer cases with adjusted verdicts that exceeded the policy limits, 92 percent (71/77) received a haircut”).

insurance in amounts that exceed the norm.⁴⁰

We investigate these dynamics below, developing a model of insurance choice for a doctor rationally reacting to an environment where plaintiffs do not pursue blood money except in cases of egregious underinsuring.

III. SIMPLE MODEL

In choosing a medical malpractice insurance policy, price and the amount of coverage⁴¹ will generally drive a physician's choice.⁴² These two factors are not independent since an individual can always purchase a policy with higher limits if she is willing to pay a higher price. This decision process might be constrained, however. Some states regulate minimum coverage levels⁴³, and even more often, hospitals will set their own higher requirements as a pre-condition for being able to practice at the hospital.⁴⁴ For simplicity, we ignore these constraints in the theoretical model that follows⁴⁵, but we include the effect of state regulations in the empirical work presented below.

We do, however, consider another influence in a physician's policy choice. In documenting the blood money phenomenon, Baker found qualitative evidence that plaintiffs were more likely to go after personal assets if the defendant consciously chose to underinsure.⁴⁶ The interview subjects in that study suggested that the definition of adequate insurance is not precise, but is instead driven by potentially evolving norms that are determined contextually. Respondents also suggested that, all other things

⁴⁰ Timothy Marjoribanks, Mary-Jo Delvecchio Good, Ann G. Lawthers & Lynn M. Peterson, *Physicians' Discourses on Malpractice and the Meaning of Medical Malpractice*, 37 J. HEALTH AND SOC. BEHAVIOR 163 (1996).

⁴¹ We do not distinguish between per-occurrence limits and aggregate annual limits. The intuition captured in the model below follows for both kinds of limits.

⁴² We ignore other terms of second order importance, such as consent to settle clauses and deductibles since they do not affect our analysis.

⁴³ See generally National Conference of State Legislatures, <http://www.ncsl.org/issues-research/banking/medical-liability-malpractice-2010-legislation.aspx> (last visited Sept. 11, 2015) (providing an overview of state regulations regarding medical malpractice limits).

⁴⁴ See Michelle M. Mello, *Understanding Medical Malpractice Insurance: A Primer*, 8 ROBERT WOOD JOHNSON FOUND. RES. SYNTHESIS REP. 1, 3 (2006).

⁴⁵ Including constraints of this type in the simple model presented below would not qualitatively change the conclusions.

⁴⁶ Baker, *Blood Money*, *supra* note 16, at 296-98.

equal, wealthier individuals were expected to maintain more insurance coverage than individuals with more limited means. This suggests that doctors will likely consider these norms when choosing their policy limits, although, given the inherent fuzziness of these norms, they will tend to operate as soft influences rather than hard constraints.

To formalize the doctor's decision process, we assume that the individual chooses only the policy limit, which in turn affects the price paid for the policy. All other terms of the policy are fixed. Further, we assume there are no legal or professional regulations that set policy limits. Lastly, we assume that the terms of the physician's policy do not affect the level of harm suffered by a plaintiff⁴⁷, but we do allow the chosen limits to affect the cost borne by the physician after an adverse event for which the physician may be held liable. We allow for this both directly, with the physician automatically being indemnified for any cost below the limit, and indirectly with the probability that a plaintiff will seek blood money for losses above the limit being an inverse function of the policy limit itself. That is, all other things equal, the likelihood a plaintiff seeks blood money will be lower as the insurance limit is higher. This indirect effect captures the norm described above.

For our model, the physician chooses L to minimize the sum of the cost of her policy $C(L)$ which is a function of the policy limit and the expected out of pocket costs she expects to pay to plaintiffs. The expected payment out of personal assets is a random variable, and so its expectation is expressed as the integral of the potential harm $H(x)$ multiplied by the associated probability distribution $f(x,L)$. As suggested above, while we do not allow the harm suffered by the plaintiff to vary as a function of the policy limit, we do allow the likelihood that the physician must bear those losses via a settlement to be a function of the policy limit. Specifically, we assume that as L increases, $f(x,L)$ declines.

The physician then solves the following:

$$\min_L C(L) + \int_L^{\infty} H(x)f(x,L)dx$$

The range of the integral goes from the policy limit (L), since the policy covers any amount up to the limit, to infinity.⁴⁸ To solve this problem, the

⁴⁷ We disallow, for example, the potential for moral hazard.

⁴⁸ More realistically, the upper bound is some measure of total available assets, perhaps including future income streams. The results that follow do not

individual takes the first derivative of the expression with respect to L and sets it equal to zero.⁴⁹ This leads to the following first order condition⁵⁰:

$$\min_L C(L) + \int_L^{\infty} H(x)f(x,L)dx$$

Rearranged:

$$\frac{\partial C}{\partial L} = H(L^*)f(x,L^*) - \int_{L^*}^{\infty} H(x) \frac{\partial f(x,L^*)}{\partial L} dx$$

This provides the standard result that the individual increases her insurance limit up to the point where the marginal cost (i.e., how much it costs to increase the limit by one dollar) is exactly equal to the marginal benefit. In this case, the marginal benefit is equal to the likelihood of facing an incremental harm just equal to the chosen policy limit and the doctor being able to satisfy his obligation for that additional harm through his insurance policy as opposed to being required to pay out of pocket, minus the expected savings garnered from not having to pay for above limit harms (because the increase in the limit lowered the likelihood of violating the underinsurance norm).

We note an interesting implication of this model. If we were to take from the haircuts literature that individual doctors are very unlikely to ever pay out of pocket to settle a claim, this would imply that at least the first element of the marginal benefit is zero. That is, if plaintiffs virtually never seek to collect damages exceeding the insurance limits, there is no benefit to extending the limits to cover an incremental harm. This suggests that a doctor's decision regarding coverage limits, ignoring regulatory requirements, will depend on the degree to which plaintiffs are willing to seek blood money due to the doctor's decision to underinsure.

What constitutes an adequate level of insurance is unclear. Interviews with lawyers suggest that it depends on the defendant's wealth and a reasonable expectation of likely damages. Doctors, especially those engaging in risky practices, appear to be held to a high standard in this regard.⁵¹

There appears, however, to be a tension between these qualitative

qualitatively depend on which upper bound is used.

⁴⁹ We assume that the relevant second order conditions are satisfied.

⁵⁰ See Akira Takayama, *Analytical Methods in Economics*, at 200 (1993) for an illustration of differentiation of a definite integral.

⁵¹ Baker, *Blood Money*, *supra* note 16, at 296-298.

impressions and the findings of the haircuts literature. Specifically, in the Texas Department of Insurance database, doctors effectively never pay out of pocket to satisfy judgments or settlement amounts. In the period 1990–2003, in the 9,525 cases with a paid medical malpractice claim, Zeiler et al. find that 98.5 percent of claims settle at or below the policy limit.⁵² Even among those few cases where payments to plaintiffs exceed the limit, physicians paid out of pocket less than half the time. In dollar terms, throughout the entire sample, physicians paid less than \$12 million total.⁵³ In expectation, this amounts to about \$30 per year for the average physician.⁵⁴

These numbers could be consistent with the qualitative findings. Perhaps Texas doctors were particularly risk averse, leading them to insure at exceedingly high levels. Zeiler et al., however, found that, contrary to conventional wisdom, Texas doctors generally carried policies with limits below \$1 million in nominal terms and did not increase the amount of coverage to keep pace with inflation.⁵⁵ Perhaps conventional wisdom overstates the real exposure faced by doctors, with Texas physicians doing a relatively good job calibrating their coverage to actual awards and settlements by holding policies with limits under the million dollar mark. This, too, is belied by the Texas data. Hyman et al. find that, on average, plaintiffs recover amounts well below what juries award. In a given case that proceeds to a judgment, the TDI data for the 1988–2003 period show haircuts of almost 30 percent. Because cases with larger verdicts are more likely to be subjected to a haircut and the haircuts themselves are generally larger when awards are bigger, more than 50 percent of money awarded is not collected by plaintiffs.⁵⁶ While some of the haircut arises due to statutory limits on damages and judicial reductions, Hyman et al. estimate that at least 73 percent of the total award reduction results from policy limits.⁵⁷ It would seem that physicians, at least those covered by the Texas data, systematically underinsure if jury verdicts are a reliable guide to what

⁵² Kathryn Zeiler, Charles Silver, Bernard Black, David A. Hyman, and William M. Sage, *Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990-2003*, 36 J. LEG. STUD. S9, S10 (2007).

⁵³ *Id.* at S25.

⁵⁴ Zeiler et al find that in the period 1990-2003, physicians paid a total \$11.8 million above policy limits out of pocket (s25). Table 2 suggests that in that period, there were, on average, 27,747 doctors in Texas, leading to an average per doctor annual exposure of \$30.38.

⁵⁵ *Id.* at S41.

⁵⁶ Hyman, *supra* note 14, at 28.

⁵⁷ *Id.* at 7.

is considered adequate insurance, yet this does not appear to regularly trigger a plaintiff's willingness to seek blood money.

Work by Stephen Gilles offers a potential explanation for the large haircuts observed in the Texas data. Gilles suggests that asset protection mechanisms, especially generous bankruptcy exemptions, effectively make defendants judgment-proof.⁵⁸ That is, even for individuals like physicians who likely have non-trivial personal assets, it is often quite easy to make those assets non-collectible.⁵⁹ After making this insight, Gilles raises the question we flag above: namely why does anyone buy liability insurance if asset protection is available for a defendant to make herself judgment-proof?⁶⁰

Gilles' answer is that, while available asset protection strategies can make an individual mostly judgment-proof, complete asset protection is not possible, leading Gilles to conclude that individuals buy less liability insurance than they would in the absence of asset protection measures, but they still buy some insurance above and beyond mandated minimums. Gilles suggests that the blood money norm – at least with respect to only pursuing a defendant's personal assets when the defendant is not adequately insured – has very little to do with fairness and much more to do with the relative difficulty of getting access to such assets.⁶¹

If Gilles is correct, we should observe that individuals systematically purchase less insurance when asset protection is easier, since they can deduce that strong asset protection measures will lead plaintiffs to settle for the amount of an insurance policy limit, even if it is inadequate. Homestead exemptions in state bankruptcy laws provide a major source of asset protection, according to Gilles.⁶² These insights may provide a partial explanation for the large haircuts and low insurance limits observed in the work using the TDI data, given that Texas had an unlimited homestead exemption throughout the period analyzed in the relevant set of papers.

IV. HOMESTEAD EXEMPTIONS

Individuals seeking to remove their debt obligations have two separate and mutually exclusive personal bankruptcy procedures in the

⁵⁸ Gilles, *supra* note 17, at 624.

⁵⁹ *Id.* at 606.

⁶⁰ *Id.* at 662-65.

⁶¹ *Id.* at 666.

⁶² *Id.* at 630.

United States: Chapter 7 and Chapter 13. The main difference between the two is that Chapter 7 requires payment from assets, but once assets are exhausted debtors have no claim on the bankrupt's future income. By contrast Chapter 13 bankruptcy requires repayment from future income, although debts are still reduced commensurate with the individual's income.⁶³ The key factor for our analysis is that bankruptcy, particularly chapter 7 bankruptcy, ends all efforts to collect debt related to personal injury torts such as medical malpractice.⁶⁴

In a Chapter 7 bankruptcy many states exempt certain assets which are protected from creditors. Typically this includes clothing, household goods and perhaps a vehicle and, most importantly for our purposes, in several states, homestead exemptions that allow a party to keep all or part of the equity in a home. Although reforms in 2005 limited the protection available for recently acquired homestead equity, these reforms only apply to a small part of the data we examine and, nevertheless, in most circumstances individuals can still avail themselves of the exemption.⁶⁵ We provide details on state homestead exemptions during the period covered by our datasets, 1988-2008 in Table 1 below. We categorize states as having zero exemption, a partial exemption, and an unlimited exemption.

We focus primarily on states with unlimited homestead exemptions because an unlimited exemption is the same everywhere and it is

⁶³ Although most of our discussion in this paper focuses on Chapter 7 bankruptcy prior to the 2005 bankruptcy reform anecdotal evidence suggests that doctors seeking to reduce a judgment in excess of insurance, if any, could still reduce their expected losses under Chapter 13 since the payments were based on ability to pay. In one example a hypothetical 6 million dollar judgment against a bare doctor cited by Foodman & Associates in 2005 could result in 5 years of payments of \$10,000 a year for a physician earning \$200,000 a year.

Moreover there are other methods for using the bankruptcy system to reduce or eliminate judgments. One of the more extreme is intentional divorce in which the doctor divorces their partner and generously gives up all the family assets in the divorce only to remarry at a later date. This may seem extreme and the stuff of situation comedy; at least on the last score it is. See for example the 2003 comedic play, "Going Bare" by Mary Jane Taegel in which an obstetrician who has dropped his liability coverage receives a \$4.2 million judgment, and conspires with his wife to get a divorce to protect their assets. Hilarity ensues.

⁶⁴ Gilles, *supra* note 17, at 648-50 (discussing the relationship between bankruptcy and tort judgments during the time period that matches most closely to the data used here and in the set of papers using the TDI data).

⁶⁵ *Id.* at 655 (discussing how most individuals can still take advantage of the homestead exemption).

qualitatively different from partial exemption or no exemption. An unlimited exemption protects all equity in a home from creditors. By contrast, states with partial exemptions vary widely in their levels.⁶⁶ For example the \$10,000 exemption in North Carolina provides much less protection than the \$100,000 exemption in Idaho, and even that relatively generous \$100,000 exemption does not provide a doctor the means to shield significant wealth provided by the unlimited exemption granted in nine states (see Table 1). Moreover, because of the clarity of the unlimited homestead exemption, bankruptcy proceedings in those nine states are often very quick, typically taking around 90 days.⁶⁷

Table 1: State Homestead Exemptions

State	Homestead Exemption	Years in Effect
AK	Partial	1988-2008
AL	Partial	1988-2008
AR	Unlimited	1988-2008
AZ	Partial	1988-2008
CA	Partial	1988-2008
CO	Partial	1988-2008
CT	0	1988-1994
CT	Partial	1994-2008
DC	0	1988-2001
DC	Unlimited	2001-2008
DE	0	1988-2001
DE	Partial	2001-2008
FL	Unlimited	1988-2008
Federal	Partial	1988-2008
GA	Partial	1988-2008
HI	Partial	1988-2008

⁶⁶ See Jeffrey Traczynski, *Divorce Rates and Bankruptcy Exemption Levels in the United States*, 54 J. L. & ECON. 751, 762-63 (2011) (showing tables with specific amounts of the exemptions in 1989, 1995, and 2005).

⁶⁷ Maureen Glabman, *New Bankruptcy Law: Blip or Blow for Florida Physicians?* FLORIDA MEDICAL BUSINESS, reprinted in SINGERXENOS, <http://www.singerxenos.com/pages/newsprint/fmbbankruptcy.html> (last visited Aug 18, 2016).

IA	Unlimited	1988-2008
ID	Partial	1988-2008
IL	Partial	1988-2008
IN	Partial	1988-2008
KS	Unlimited	1988-2008
KY	Partial	1988-2008
LA	Partial	1988-2008
MA	Partial	1988-2008
MD	0	1988-2008
ME	Partial	1988-2008
MI	Partial	1988-2008
MN	Unlimited	1988-1993
MN	Partial	1997-2001
MO	Partial	1988-2008
MS	Partial	1988-2008
MT	Partial	1988-2008
NC	Partial	1988-2008
ND	Partial	1988-2008
NE	Partial	1988-2008
NH	Partial	1988-2008
NJ	0	1988-2008
NM	Partial	1988-2008
NV	Partial	1988-2008
NY	Partial	1988-2008
OH	Partial	1988-2008
OK	Unlimited	1988-2008
OR	Partial	1988-2008
PA	0	1988-2008
RI	0	198-2001
RI	Partial	2002-2008
SC	Partial	1988-2008
SD	Unlimited	1988-2008
TN	Partial	1988-2008
TX	Unlimited	1988-2008
UT	Partial	1988-2008

VA	Partial	1988-2008
VT	Partial	1988-2008
WA	Partial	1988-2008
WI	Partial	1988-2008
WV	Partial	1988-2008
WY	Partial	1988-2008

Source: Elias, S., Renuauer, A., and Leonard, R. *How to File for Bankruptcy*, various editions Berkeley, Calif.: Nolo Press 1988-2008

Prior to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 Act, there was no income test for Chapter 7, so an individual could discharge debts without a claim on future income, regardless of how high that income is. In effect, this allowed bankrupt individuals to protect almost all of their other assets in states with unlimited homestead exemptions, by simply taking non-exempt assets and using them to pay down a mortgage or buy a larger house.⁶⁸

In fact the threat of bankruptcy is also rumored to play an important role in settlement negotiations in states with unlimited exemptions. For example, the Florida Medical Business letter reported that, in Florida, which has an unlimited exemption:

“Bankruptcy [is] a hammer for bare doctors,: according to Marc Singer, a Coral Gables. “We’ve used the threat of bankruptcy in about 100 cases to help achieve reasonable settlements with plaintiff attorneys.”⁶⁹

Indeed, the Florida legislature allowed doctors to go without insurance

⁶⁸ There are limits on the timing of such asset reclassification but these are typically fairly short and for medical malpractice cases which can take considerable time to resolve allow doctors who suspect they are facing a large liability judgment plenty of time to reclassify assets before the judgment is recorded. See Glabman, *supra* note 67, (discussing the implications for the 2005 Act on physicians’ ability to protect assets). Case law in a number of states has also found that debts expunged by bankruptcy are still the legal obligation of the insurance company so that even if debt was discharged by bankruptcy the insurance company still had to pay. See *Matter of Edgeworth*, 993 F.2d 51, 56 (5th Cir. 1993) in which a Florida doctor’s judgment was expunged. The Court found that despite the bankruptcy the doctor insurer still had a legal obligation to pay the judgment up to the policy limit.

⁶⁹ See Glabman, *supra* note 67.

starting in 1987 (allowing them to post a bond instead).

Following the 2005 Act, debtors can no longer simply choose the type of bankruptcy they wish to pursue, because access to chapter 7 is now means tested. For this reason, we confine ourselves to cases prior to the date in 2005 when the Act's provisions took effect.⁷⁰

How important are homestead exemptions in determining the size of the haircuts on the amounts that physicians would otherwise have to pay? The large haircuts identified in the TDI dataset are striking, both because of their frequency and their size. Given the norm identified in the blood money literature, these findings are especially surprising in light of the low level of insurance coverage purchased by Texas physicians on average.⁷¹

Gillie's insight about asset protection and homestead exemptions in state bankruptcy laws provides a potential explanation. If this explanation is correct, it significantly limits the generalizability of the Texas findings, because only a few other states have the same generous exemptions as Texas.⁷²

⁷⁰ The Act was signed into law by President Bush on April 20, 2005 with the provisions applying to cases filed on or after October 17, 2005. See *Bankruptcy Abuse Prevention and Consumer Protection Act of 2005*, PUB. L. NO. 109-8, 119 Stat. 23. See also Michelle J. White, *Bankruptcy Reform and Credit Cards*, 21 J. ECON. PERSP. 175-99 (2007).

⁷¹ See Baker, *supra* note 16, at 297-98 quoting a plaintiff's lawyer as follows: "We have a case now where a doctor testified at his deposition that his group got together and they consciously made a decision to have million dollar policies despite the fact that they are obstetricians and they know that their exposure is greater, because they understood that if they only carried a million dollars, the case would settle for a million dollars and they would be better off. And under those circumstances, where someone has made that kind of a conscious decision to be underinsured, I would feel less compunction about going after them, and the client probably would also."

Note the hypothetical nature of the claim. On close analysis, very few of the Connecticut lawyers' statements are inconsistent with a more straightforward rational actor explanation, as Gilles has previously noted. See Gilles, *supra* note 17, at 666 ("whatever their moral beliefs may be, the self-interest of plaintiffs' attorneys appears sufficient to explain the professional norm to which most of them subscribe").

⁷² Interestingly, Florida is the only other state with similarly public medical malpractice claim payment literature though the data have not been as fully mined as the Texas data. See generally Neil Vidmara, Kara MacKillop & Paul Lee, *Million Dollar Medical Malpractice Cases in Florida: Post-Verdict and Pre-Suit Settlements*, 59 VAND. L. REV. 1343 (2006) (finding substantial post-judgment

A conclusion that bankruptcy exemptions drive the Texas haircut results, however, is premature. Such a conclusion requires a more rigorous statistical analysis than is possible with data from a single jurisdiction. To examine this hypothesis, we require data from multiple jurisdictions to be able to compare insurance limits in states with generous exemptions to the insurance limits observed in states with more modest bankruptcy protections. That is the primary contribution of this Article.

V. EMPIRICAL EVIDENCE

We examine three data sources each of which contains slightly different information relevant to our hypothesis. Our theory relies on the claim from the quantitative TDI research and the qualitative claims of the blood money literature that doctors generally will not be forced to pay out of pocket to satisfy settlements and judgments even if the latter exceed the doctor's insurance policy limit unless the doctor is perceived as having under-insured. The desire to avoid the risk of paying out of pocket due to a violation of the adequate insurance norm is likely to be decreasing in the ability of doctors to protect their assets through other mechanisms, such as bankruptcy law. If these assumptions are correct, we should find that, all other things equal, settlements (pre or post judgment) should be lower in states that have more generous bankruptcy exemptions. We test this implication using data from the National Practitioner Data Bank, finding support.

Second, given the validation of those assumptions, our model predicts that demand for insurance should be lower in jurisdictions with more generous bankruptcy exemptions. This implies that prices for medical malpractice policies should be lower in these jurisdictions for a given coverage level.⁷³ Using data from the Medical Liability Monitor, we find

haircuts). Because both Texas and Florida have such unusually generous bankruptcy exemptions, the results from both data sets may not generalize nationally.

⁷³ Take the standard result that a monopolistic competitor sets marginal revenue equal to marginal cost when maximizing profit (see Andreu Mas-Colell, Michael Winston, and Jerry Green, *Microeconomic Theory*, at 386 (1995)). If we express marginal revenue in terms of the elasticity of demand, we have

$$MR_i = P_i \left(1 + \frac{1}{e_i} \right) \text{ (see Alph Chiang, } \textit{Fundamental Methods of Mathematical Economics}$$

Economics, 3rd ed., 357 (1984)), where e_i is the elasticity for demand for good i ,

results supporting this hypothesis. Last, to validate the model's implication that doctors will choose lower coverage levels when bankruptcy protections are stronger, we examine data from an insolvent medical malpractice insurer that offered policies in many different states. The results from this dataset are consistent with the prediction of the model.

In several of the specifications discussed below we also include controls for differences in state tort law. We use Ronen Avraham's Database of State Tort Law Reforms (DSTLR 4th) which is a comprehensive reference of changes in state tort law from 1980 to the present.⁷⁴ The DSTLR 4th edition contains information about state caps on punitive damages, caps on total damages, and caps on non-economic damages if those caps apply to medical malpractice cases. We also include information on which states limited joint and several liability and a control for those states that enacted periodic payment statutes forcing plaintiffs to receive certain settlements intermittently rather than as a lump sum. We include controls for states that have changed the standard necessary to receive punitive damages and states that divide punitive damages between the plaintiff and the state. We include an indicator variable if the state has modified the collateral sources rule in order to prevent plaintiffs from collecting from both a defendant and insurance. We include an indicator variable if the state has capped contingent fees. Finally we include an indicator variable if the state has created a patients' compensation fund to pay damages in support of plaintiff verdicts above a certain threshold amount.

These reforms are typically enacted in clusters making it impossible to determine the independent effect of each reform. Since we are interested in the impact of homestead exemptions, which to our knowledge have never been part of a tort reform package, we do not attempt to disentangle the individual effects of the tort reform laws in the Avraham database.

we can solve for the price of good i as $P_i = \frac{MC_i}{1 + \frac{1}{e_i}}$. Thus, for a fixed marginal

cost, it is easy to see that a larger (in magnitude) elasticity of demand will lead to a lower price (since elasticities are negative).

⁷⁴ Ronen Avraham, *Database of State Tort Law Reforms (DSTLR 5th)*, UNIV. OF TEX. SCH. OF LAW, LAW & ECON. RESEARCH PAPER NO. E555, May 2014, available at <http://dx.doi.org/10.2139/ssrn.902711>.

VI. MEDICAL MALPRACTICE DATASETS

A. NATIONAL PRACTITIONER DATA BASE

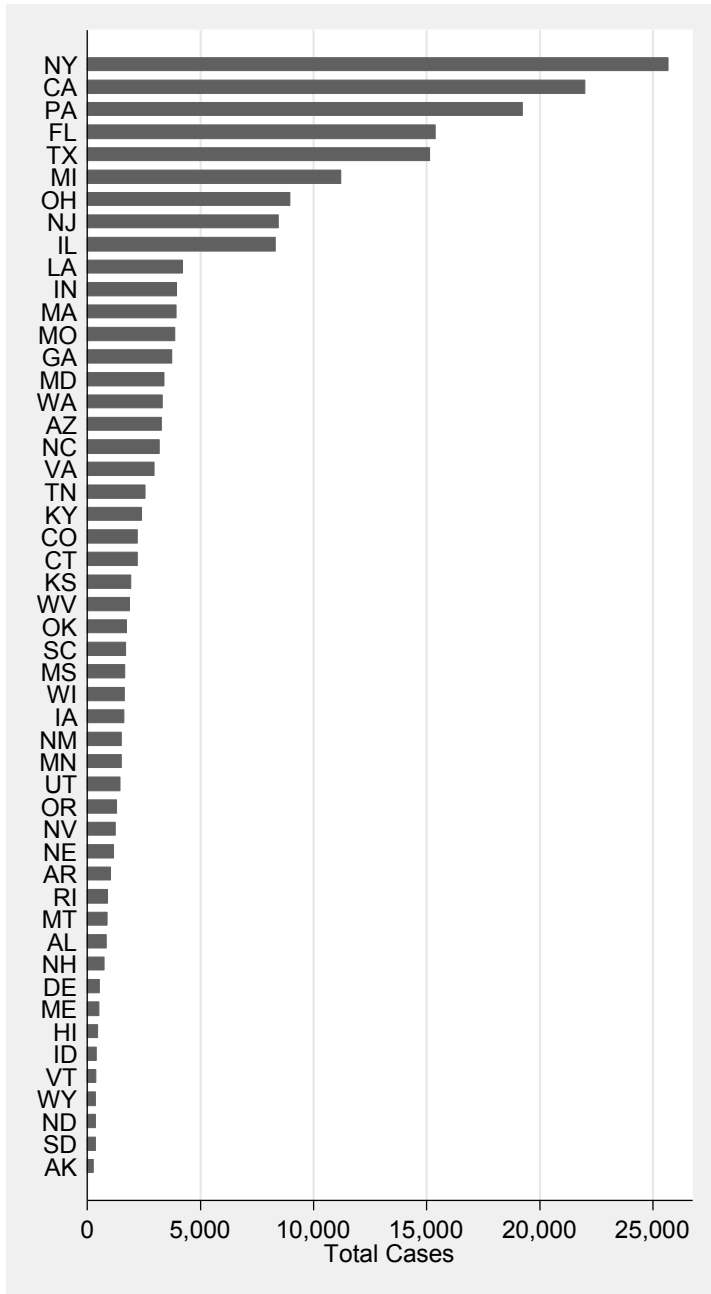
The National Practitioner Data Bank (NPDB) includes information on all payments made to settle a claim or a judgment against a physician in the medical malpractice context. Reporting is mandatory under the Health Care Quality Improvement Act of 1986.⁷⁵ Given the nationwide scope of this mandate, the NPDB is a comprehensive dataset.

The database contains information on over 200,000 medical malpractice payments made on behalf of practitioners in all 50 states and the District of Columbia.⁷⁶ This national dataset helps us evaluate whether the low payments observed in the TDI data are common in states with generous bankruptcy protections. We use the data between 1990 (the start of the database) and 2005 to avoid the national bankruptcy law change. We also drop the handful of trials in the sample though this does not affect our results. In Figure 1 we present the distribution of NPDB claims across states.

⁷⁵ 42 U.S.C. 11101.

⁷⁶ The NPDB has several well-known limitations. See Eric Helland, Jonathan Klick & Alexander Tabarrok, *Data Watch: Tort-Uring the Data*, 19 J. ECON. PERSP. 207 (2005) (discussing the NPDB).

Figure 1: Distribution of Settlements in National Practitioners' Database.



The summary statistics for the NPDB are given below. The data also contain information on the type of medical error, the doctor's age and the year in which the doctor received his or her medical degree.

Table 2: Summary Statistics for the NPDB

	Mean	Standard Deviation
Payment amount	213,555	351,814
Unlimited Homestead Exemption (1=yes)	0.18	0.39
Physician age	47.99	10.48
Graduation Year		
Pre 1940	0.00	0.06
1940-49	0.03	0.16
1950-59	0.11	0.31
1960-69	0.24	0.43
1970-79	0.31	0.46
1980-89	0.25	0.43
1990-99	0.05	0.22
Post 1999	0.00	0.02
Medical Error		
Diagnosis	0.34	0.47
Anesthesia	0.03	0.17
Surgery	0.28	0.45
Medication	0.06	0.23
IV/blood	0.00	0.06
Obstetrics	0.08	0.26
Treatment	0.18	0.38
Monitoring	0.01	0.12
Equipment	0.00	0.06
Behavior	0.00	0.02
State minimum policy limit per occurrence	92,178	230,135
Observations	197,695	

The estimated model is:

$$\begin{aligned} \text{settlement amount}_{it} \\ = \alpha + \beta \text{unlimited homestead exemption}_i + \tau_t + \theta X_i \\ + \varepsilon_{it} \end{aligned}$$

where the homestead exemption variable is an indicator taking the value of 1 if a state has an unlimited exemption and zero otherwise. X includes the doctor specific controls mentioned above, state tort law controls and the alleged injury. The model also includes individual year dummies to account for any nationwide trends in settlement amounts.

The results are presented in Table 3. We find that an unlimited homestead exemption is associated with lower settlement payments. We find that the settlement payments are \$34,000 lower in the NPBD, and the percentage impact is about 14 percent. When estimated in logs rather than levels, in column 3 we find that point estimate declines slightly to a 9 percent drop but continues to be negative and significant.

Table 3: NPDB Settlement Results

Variables	Payment	ln(Payment)
Unlimited	-33,752***	-0.10***
Homestead Exemption	(6,983)	(0.03)
Percentage Change in Settlement Amount	-14%	-9%
Observations	189,814	189,814

Control variables included in regressions: Physician age, graduation year cohort, alleged injury, year dummies, state tort reforms

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Our estimates from the NPDB confirm that Texas and the other states with unlimited bankruptcy exemptions exhibit systematically lower settlements. The magnitude of this reduction is statistically significant and quantitatively large.

While the regression results presented in Table 3 above may suffer from omitted variable bias, it does suggest that this set of states, including Texas, is systematically different for some reason. The characteristic that

these states have an unlimited homestead exemption may be correlated with some other unaccounted for factor that drives settlement amounts down. In some sense, this alone is enough to draw into question the extent to which the Texas settlement and haircut results can be generalized. Texas, and the other states in this group, are systematically different from the majority of states in the U.S.

It is not generally possible to guarantee that the unlimited homestead exemption is driving this result, short of running some kind of randomized policy experiment where homestead exemptions are randomly assigned to states. Given the limited in-state variation in the exemption amounts within this set of states, it is not even possible to examine a so-called natural experiment that proceeds as if the policy change is conditionally exogenous to other things affecting settlement amounts in the states. However, we can provide some confidence by examining the other predictions generated by our model above; namely, if the homestead exemption provides an additional avenue by which doctors protect their income, the elasticity of demand for the insurance should increase, lowering the equilibrium price for coverage in this set of states. Also, if the presence of these exemptions is driving the lower settlement amounts, we should observe systematically lower insurance limits in this set of states.

B. MEDICAL LIABILITY MONITOR SURVEY

Our model, given the assumption, that bankruptcy protections lead to lower settlements, suggests that demand for medical malpractice insurance should be lower in jurisdictions with large protections, which should lead to lower prices in those jurisdictions. To examine the impact of homestead exemptions on premiums, we turn to an annual survey conducted by Medical Liability Monitor.

The survey began in 1991 and our data ends in 2002. The survey collects data on the premium for a hypothetical policy offering \$1 million in coverage for a claim and \$3 million per year. The data provides information at the company level for different regions within a state (i.e. major cities) and for three specialties: internal medicine, general surgery and obstetrics- gynecology. Thus the unit of observation for our analysis is the state- region-company-year for each of the three specialties. For example the data would provide us with the premium for an OBGYN in Los Angeles in 1999 offered by the Doctors Company. Since medical professional liability is not experience rated, the premiums reflect the price faced by all doctors of a particular specialty that the insurer is willing to

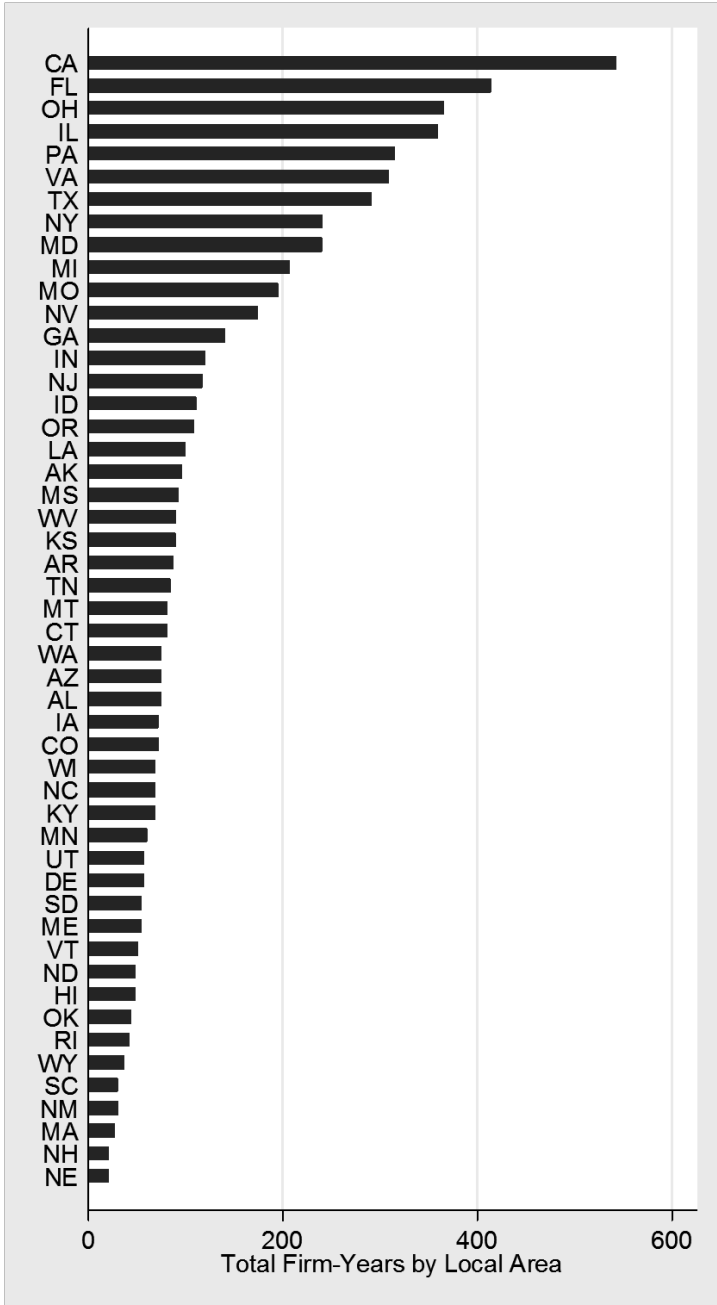
insure.⁷⁷

We examine the data at the company level for two reasons. First, companies enter and exit the survey in various years and for various reasons. We cannot determine if the company exited the market completely or simply did not report data for some region or specialty. Though we have no reason to suspect that reporting is correlated with homestead exemptions, to control for any composition bias that might result from differential reporting, we include company-region-state fixed effects. Second, the state-region fixed effects allow us to control for sizeable differences in litigation rates across different regions in states, something that none of our datasets allow us to control for directly.

Because the data is at the company-region level, we have a different number of observations across states, with California having the largest number of company-regions. We provide the breakdown of the sample by state in Figure 2.

⁷⁷ See Katherine Baicker and Amitabh Chandra, *Defensive Medicine and Disappearing Doctors?* 28 *Regulation* 24 (2005) for more details on MLM data.

Figure 2: Distribution of Policies Observed in Medical Liability Monitor Data



In Table 4 we present the summary statistics from the MLM survey. There is very wide variation in premiums faced by doctors, with the lowest being a \$14 per year premium offered in 1992 to general surgeons in rural Tennessee, while the highest premium was offered to OBGYNs in 1991 in Detroit (\$214,301).

Table 4: Summary Statistics for the Medical Liability Monitor data (1991-2002)

	Mean	Standard Deviation
Real Annual Premium	28,978	26,020
Unlimited Homestead Exemption	0.17	0.38
Minimum Policy Limit Per Occurrence	61,304	163,905
Observations	6,303	

The model is estimated using ordinary least squares and is specified as

$$premium_{ist} = \alpha + \beta unlimited\ homestead\ exemption_i + \tau_t + \varphi_i + \theta X_s + \varepsilon_{its}$$

where premium is the annual premium identified in the data, unlimited homestead exemption retains its meaning, τ are the year indicators, φ are state-region fixed effects, X includes indicators for the three specialties.

The results are presented in Table 5. We again estimate the model in logs and levels. We find that premiums are on average about \$3,300 lower, for the same amount of coverage, in states with unlimited homestead exemptions than states without an unlimited exemption. This represents about a 9.7% reduction in premiums. In column three we estimate the model using the log of premiums and again find a reduction in the premiums in states with unlimited homestead exemptions. In this case the estimated effect is smaller, about 3.6%.

Table 5: Medical Liability Monitor Premium Regressions

Variables	Premium	ln(Premium)
Unlimited	-3,372***	-0.04*
Homestead Exemption	(1,081)	(0.02)

Percentage Change in Premium	-9.7%	-3.6%
Observations	6,285	6,285

Control variables included in regressions: Area fixed effects, year dummies, doctor specialty dummies
Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

We find that physicians in states with unlimited homestead exemptions systematically have lower premiums, suggesting a reduction in demand for insurance by doctors in those states.

C. INSOLVENT INSURER

To further investigate the validity of our theoretical claims, the last dataset we use includes all closed claims from a large medical malpractice insurer that provided policies throughout much of the United States until it went insolvent in the mid-2000s. These data include information on the payments made, the (per occurrence and annual aggregate) policy limits, the physician specialty, and details about the injury. We provide summary statistics in Table 6

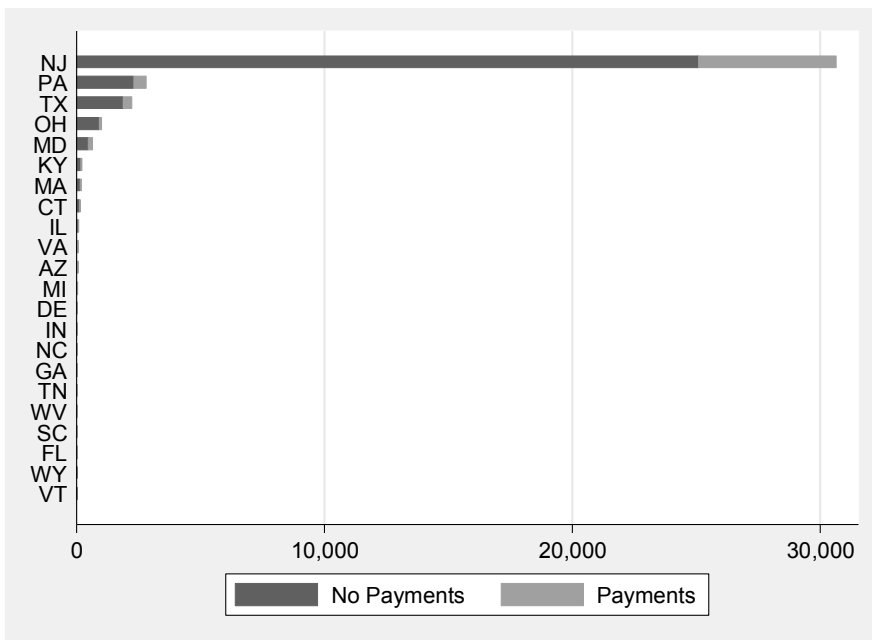
That insolvent insurer's data has several advantages over publicly available medical malpractice data such as the TDI data, as well as the comparable datasets for Florida. For our purposes, the most important is that the insurer has claim data from multiple states, including several without homestead exemptions. Unlike the National Practitioner Database (NPDB), the insolvent insurer's data also contains information on claims that were closed without payment (either because they were unilaterally dropped by the plaintiff or there was a defense verdict at trial), as well as information on policy limits. The insolvent insurer data also contains information on the specialty of the doctor involved and the type of injury.

Table 6: Insolvent Medical Malpractice Insurer Data Summary

	Mean	Standard Deviation
Settlement Amount	45,701	174,760
Aggregate Policy Limit	2,274,695	2,147,062
Per Occurrence Policy Limit	548,477	485,886
Observations		38,324

While the insurer sold policies throughout much of the country, its policies were not evenly distributed across states. Figure 3 provides the distribution of policies by state observed in this dataset. For our purposes, the value of this data is somewhat limited in that the only states with unlimited bankruptcy exemptions for which we observe any settlements are Texas and Florida, with the latter providing relatively few observations. At a minimum, these data can show if Texas and Florida are systematically different from the rest of the states in the dataset in terms of insuring practices and settlement behavior. Some of this heterogeneity is likely associated with the bankruptcy provisions in those states given our NPDB results; however, confidence in this claim is necessarily limited given the data availability.

Figure 3: Distribution of Policies Observed in Insolvent Medical Malpractice Insurer Data



We begin by estimating the impact of unlimited homestead exemptions on the total policy limit⁷⁸ chosen by doctors using the following

⁷⁸ The results are qualitatively similar if we instead use the per

specification,

$$\text{policy limit}_{it} = \alpha + \beta \text{unlimited homestead exemption}_i + \theta X_i + \tau_t + \varepsilon_{it}$$

where policy limit is the per occurrence policy limit in 2005 dollars, unlimited homestead exemption equals one if the state in question has an unlimited homestead exemption, τ are year indicator variables, X is the set of control variables include state tort laws and indicator variables for the different specialty of the doctor involved in the lawsuit.

The results are presented in Table 7. The model is estimated in both levels and logs. The results indicate that the physicians sued in states with an unlimited homestead exemption have a 65% lower policy limit than those sued in states without the unlimited homestead exemption. There are two possible effects that could be driving this result. First, physicians may be systematically choosing lower policy limits in the states in which they can protect their assets from a judgment. Second, the selection of cases may be different in states with unlimited exemptions. This second effect would tend to bias the result toward zero, however, as plaintiffs' attorneys would be more likely to pursue cases in which the doctor had, for whatever reason, selected a higher policy limit. Thus, this possible selection effect likely makes our conclusion about the impact of bankruptcy exemptions even stronger.

Table 7: Policy Limit Regressions Insolvent Insurer Data

Variables	Policy Limit	ln(Policy Limit)
Unlimited	-1,781,226***	-1.19***
Homestead Exemption	(142,506)	(0.04)
Percentage Change in Policy Limit	65.3%	-70%
Observations	36,441	36,441

Control variables included in regressions: Year dummies, state tort reforms, physician specialty dummies

Robust standard errors in parentheses

*** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

occurrence policy limit as the dependent variable.

In Table 8 we estimate the impact of unlimited homestead exemptions on settlements using a Tobit regression. A Tobit regression corrects for situations in which the dependent variable is truncated in some way.⁷⁹ This is important in our insolvent insurer data because there are 327 cases (about .08%) in which the payment exceeds the policy limit. For some of those cases, the excess amount paid, if any, is not identified. It is unclear why the excess is reported in some cases but not in others, so we err on the side of caution and treat the observations as truncated at the policy limit if the excess is not reported. The results are robust to excluding the missing observations and estimating the model using ordinary least squares. The model is specified as,

$$\begin{aligned} \text{settlement amount}_{it} \\ &= \alpha + \beta \text{unlimited homestead exemption}_i + \tau_t + \theta X_i \\ &+ \varepsilon_{it} \end{aligned}$$

where settlement amount is the payment by the insurer, unlimited homestead exemption retains its meaning from above, τ are year indicator variables, X includes controls for specialty, the severity of the injury as determined by the insurer (classified as minor, major, death emotional injuries, or no injury), and whether the injured party is a child.

The results are presented in Table 8. In column two we estimate the model with all of the available cases prior to 2005 and find that the presence of an unlimited homestead exemption reduces settlement amounts by over \$19,000. As would be expected, the results are larger when we confine ourselves to those cases which settle for a positive value rather than being closed without payment.⁸⁰ The impact rises to \$70,000 per case, which represents a 26% drop in payment amounts as compared to settlements in states without an unlimited homestead exemption. By contrast when the model is estimated including the \$0 payment cases, we find a 44% reduction in payments suggesting a significant number of cases are dropped in the face of an unlimited homestead exemption. In column 3 we estimate the model using the log of the settlement amount which also

⁷⁹ See the entry on Tobit Regressions, StataCorp. 2009. Stata 11 Base Reference Manual. College Station, TX: Stata Press and Wooldridge, J. M. 2009. Introductory Econometrics: A Modern Approach. 4th ed. Cincinnati, OH: South-Western.

⁸⁰ One reason for estimating the model using only the cases closed with a positive payment is to allow for better comparison of the results using the insolvent insurer data with results using the Texas and NPDB data, because both of those datasets do not include cases closed with zero payment.

eliminates the cases settling for no payment. We find that the homestead exemption is associated with about a 20% decline in payments to plaintiffs.

Table 8: Settlement Amounts Insolvent Insurer Data

Variables	Settlement Amount	Settlement Amount > 0	ln(Settlement Amount)
Unlimited Homestead Exemption	-19,983*** (4,143)	-70,882*** (20,911)	-0.21** (0.08)
Percentage Change in Settlement Amount	-44%	-26%	-19%
Observations	36,442	6,402	6,402

Control variables included in regressions: Year dummies, physician specialty dummies, injury severity dummies, dummy for whether victim was child

Robust standard errors in parentheses

***p<0.01, **p<0.05, *p<0.10

The results from our insolvent insurer data indicate that doctors in states with an unlimited homestead exemption systematically pay out less in settlements and select lower policy limits. This is consistent with our hypothesis that doctors in these states have greater bargaining power in settlement negotiations and, hence, decide to insure less, because their assets are at less risk. Note that these settlement reductions line up nicely with the proportional size of the haircuts identified in the TDI data, supporting our concern about the generalizability of the findings from the Texas research. While the results are consistent with the bankruptcy exemption hypothesis, they could also be driven by other peculiar aspects of Texas and Florida.

Thus, again, at a minimum, our results suggest that Texas and Florida are peculiar relative to the other states covered in the dataset. This draws into question any attempt to extrapolate from these states to predict what occurs in other markets with respect to medical malpractice insurance policies and settlements. Further, the results are at least consistent with our hypothesis that the existence of an unlimited homestead exemption is important in understanding the dynamics of the Texas insurance market and the settlement environment in that jurisdiction.

VII. ROBUSTNESS CHECKS AND CAVEATS

In this section we explore two robustness checks on our results. The first is to include state minimum policy requirements in the regression. During the sample period several states required doctors to have a specified minimum insurance policy. Clearly this will affect the policy limits chosen by the doctor and may impact settlement negotiations. The concern that led us to first analyze the data without considering these minimum insurance requirements is that plaintiffs' attorneys may lobby to have minimum policy limits in those states with unlimited homestead exemptions, thus leading to an endogenously-driven correlation between the requirements and the unlimited exemption. We have no anecdotal evidence of this, and states with unlimited homestead exemptions do not appear to be systematically overrepresented among the states with minimum policy requirements. Nevertheless, we treat the results including the minimum requirements as a robustness check, rather than including the limits in our primary specifications.

A. MINIMUM COVERAGE REGULATIONS

Between 1988 and 2008 13 states had some sort of minimum liability coverage for doctors. The limits are summarized in Table 9. The amounts are typically small relative to the policy limits found in the insolvent insurer data; although one state, Pennsylvania, does require one million dollars of per incident coverage.

Table 9: Summary of State Rules Covering Minimum Liability Insurance

State	Rule	Years
AK	none	1988-2008
AL	none	1988-2009
AR	none	1988-2010
AZ	none	1988-2011
CA	none	1988-2012
CO	none	1988-2013
CT	none	1988-1994
CT	\$500,000	1995-2008
DE	none	1988-2008

FL	\$100,000	1988-2008
GA	none	1988-2008
HI	none	1988-2008
IA	none	1988-2008
ID	none	1988-2008
IL	none	1988-2008
IN	\$250,000	1988-2008
KS	none	1988-2008
KY	none	1988-2008
LA	none	1988-2008
MA	\$100,000	1988-2008
MD	none	1988-2008
ME	none	1988-2008
MI	none	1988-2008
MN	none	1988-2008
MO	\$500,000	1988-2008
MS	none	1988-2008
MT	none	1988-2008
NC	none	1988-2008
ND	none	1988-2008
NE	none	1988-2008
NH	none	1988-2008
NJ	none	1988-1994, 1998-2001
NJ	\$1,000,000	1995-1997, 2002-2008
NM	none	1988-2008
NV	none	1988-2008
NY	none	1988-2008
OH	none	1988-2008
OK	none	1988-2008
OR	none	1988-2008
PA	none	1988-2008
PA	\$100,000	1988-1996
PA	\$300,000	1997-1998
PA	\$400,000	1999-2000

PA	\$500,000	2001-2002
PA	\$1,000,000	2003-2008
RI	none	1988-2008
SC	\$100,000	1988-2008
SD	none	1988-2008
TN	none	1988-2008
TX	none	1988-2008
UT	none	1988-2008
VA	none	1988-2008
VT	none	1988-2008
WA	none	1988-2008
WI	none	1988-2008
WV	none	1988-2008
WY	\$50,000	1988-2008

For each of the regressions presented in section 6 above, we now include the minimum policy limit (which is either zero for states without the limit or the limit itself) for the relevant years.

In Table 10 we estimate the NPDB regressions including minimum policy requirements.

Table 10: NPDB Settlement Regressions with Minimum Policy Limits

Variables	Payment	ln(Payment)
Unlimited	-22,312***	-0.02
Homestead Exemption	(8,181)	(0.04)
Minimum Policy Limit Per Occurrence	0.05***	0.000***
Percentage Change in Settlement Amount	-10%	-2%
Observations	189,814	189,814

Control variables included in regressions: Physician age, graduation year cohort, alleged injury, year dummies, state tort reforms

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

While the magnitudes of our homestead exemption effects decline somewhat, they are still negative and the results in the regressions using the level of the settlement is still statistically significant at the 1 percent level. The minimum policy limit amounts are positively correlated with settlement amounts. Despite the decline in coefficient magnitude, these results are generally consistent with those presented above.

In table 11 we estimate our premium regressions using the MLM data, taking into account the minimum policy requirements. We again find that states with unlimited homestead exemptions have lower annual premiums. The impact is very similar to the results obtained when we do not include the minimum policy requirements.

Table 11: Medical Liability Monitor Premium Regressions with Minimum Policy Limits

Variables	Premium	ln(Premium)
Unlimited	-3,377***	-0.04*
Homestead Exemption	(1,082)	(0.02)
Minimum Policy Limit Per Occurrence	0.001 (0.003)	0.000 (0.000)
Percentage Change in Premium	-10%	-3.6%
Observations	6,285	6,285

Control variables included in regressions: Area fixed effects, year dummies, doctor specialty dummies

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

The results of our policy limit specification using the insolvent insurer are presented in Table 12. Even when we include controls for minimum policy requirements, which do cause a statistically significant increase in the level of coverage chosen by doctors, we still find that unlimited homestead exemptions reduce the amount of coverage selected by doctors. Moreover this effect is quite large, with doctors in states with unlimited homestead exemption states selecting 61% less coverage than in states in which less asset protection is available. These results are virtually identical to those discussed above.

Table 12: Policy Limit Regression with Minimum Coverage Control

Variables	Policy Limit	ln(Policy Limit)
Unlimited Homestead Exemption	-1,666,266*** (149,933)	-1.11*** (0.04)
Minimum Policy Limit	0.22** (0.09)	0.00*** (0.00)
Percentage Change in Policy Limit	-61.1%	-67%
Observations	36,441	36,441

Control variables included in regressions: Year dummies, state tort reforms, physician specialty dummies
 Robust standard errors in parentheses
 *** p<0.01, ** p<0.05, * p<0.1

In Table 13 we estimate the settlement amount specifications using the insolvent insurer data. As predicted, minimum policy requirements increase the amount of settlement in all specifications. We continue to find that unlimited homestead exemptions reduce the amount of settlement when we include zero payment cases. When we drop cases with zero payments from the data, the impact of unlimited exemptions is negative but not significant. Finally when we use the log of settlement amounts the coefficient on unlimited homestead exemptions is not significant and flips sign. As explained below the instability of these results may be the result of the reduction in sample size when the zero payment cases are excluded.

Table 13: Settlement Amounts Insurer Database with Minimum Policy Limit

Variables	Settlement Amount	Settlement Amount>0	Ln(settlement Amount)
Unlimited Homestead Exemption	-10,649** (4,939)	-27,324 (24,652)	0.07 (0.10)
Minimum Policy Limit Per Occurrence	0.01*** (0.00)	0.06*** (0.017)	0.00*** (0.00)
Percentage Change in Settlement Amount	-21%	-10%	7.7%
Observations	36,442	6,402	6,402

Control variables included in regressions: Year dummies, physician specialty dummies, injury severity dummies, dummy for whether victim was child

Robust standard errors in parentheses

*** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

The results of this robustness check are not as comforting. While we continue to find a negative effect of unlimited homestead exemptions on settlement amounts in the level regressions, the log specification generates a coefficient that is essentially zero. Further, even in the level specifications, the magnitude of the coefficients declines substantially.

The results of our first robustness check indicate that, while minimum policy limits do increase coverage amounts and settlement payments, the impact of unlimited homestead exemptions retains its significance in most specifications. We now turn to a second inquiry: Do partial homestead exemptions generate similar, though smaller in magnitude, effects?

B. IMPACT OF PARTIAL HOMESTEAD EXEMPTIONS

In this section we examine the impact of partial homestead exemptions that allow some sheltering of assets. The classification is far less clear cut than the unlimited homestead exemption, because unlimited states have very few restrictions on the nature and the amount of home equity that can be protected. By contrast, states with partial exemptions often have specific qualifications. For example, Connecticut allows the exemption only for certain hospital debts and Maine requires dependents to qualify. We have no systematic way to capture these specific qualifications, and so we treat the partial homestead exemption as a dummy variable, recognizing that it will be estimated with more noise than our unlimited homestead exemption variable.

We estimate the NPBD regressions including indicator variables for both unlimited and partial homestead exemptions. The results are presented in Table 14. Consistent with our original findings, we estimate that both kinds of exemptions are associated with lower settlements, whether the payment is estimated in levels or logs. Interestingly, the effect of partial exemptions is smaller than the effect of unlimited exemptions, at least in the level specification, and this difference is statistically significant.

Table 14: Settlement Amount Regressions NPDB with Both Unlimited and Partial Homestead Exemption Controls

Variables	Payment	ln(Payment)
Unlimited	-46,803***	-0.24***
Homestead	(7,417)	(0.03)
Exemption		
Partial Homestead	-21,650***	-0.25***
Exemption	(7,017)	(0.03)
Percentage Change in Settlement Amount	-19%	-22%
Observations	189,814	189,814

Control variables included in regressions: Physician age, graduation year cohort, alleged injury, year dummies, state tort reforms

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

We find similar effects in the Medical Liability Monitor regressions, with the unlimited homestead exemption generating a negative effect that is larger in magnitude than the effect associated with a partial homestead exemption at least in the level specifications. Given that a partial exemption has much less utility as an asset protection mechanism, this is what our model predicts. The coefficients in the log specifications are essentially equal. The results are generally not very precise though, so while the point estimates are largely consistent with theory, we cannot conclude with confidence that the results could not be the result of random associations in the data.

Table 15: Medical Liability Monitor Premium Regressions with Both Unlimited and Partial Homestead Exemption Controls

Variables	Premium	ln(Premium)
Unlimited Homestead	-3,378	-0.01
Exemption	(3,216)	(0.10)
Partial Homestead	-6.00	0.03
Exemption	(2,987)	(0.09)
Percentage Change in Premium	-10%	-0%
Observations	6,285	6,285

Control variables included in regressions: Area fixed effects, year

dummies, doctor specialty dummies
 Robust standard errors in parentheses
 *** p<0.01, ** p<0.05, * p<0.1

The results of our policy limit regressions are shown in Table 16. Using the insolvent insurer data, we find similar impacts from the unlimited exemptions, but we find positive and significant impacts of partial exemptions on policy limits. This is surprising since the omitted category is no limit. Thus, the results suggest that the highest policy limits chosen are chosen in states with partial homestead exemptions.

Table 16: Policy Limit Regressions with Both Unlimited and Limited Homestead Exemption Controls

Variables	Policy Limit	ln(Policy Limit)
Unlimited	-1,715,926***	-1.18***
Homestead	(143,053)	(0.04)
Exemption		
Partial Homestead	678,991***	0.11***
Exemption	(135,485)	(0.04)
Percentage Change in Limit	-75%	-60%
Observations	36,441	36,441

Control variables included in regressions: Year dummies, state tort reforms, physician specialty dummies
 Robust standard errors in parentheses
 *** p<0.01, ** p<0.05, * p<0.1

The results of our settlement regressions are shown in Table 17. The first column reports the results using all of the cases in the insolvent insurer data. The second column reports the results when we eliminate the zero payment cases. The third column reports the results using the log of the settlement amount. In all three specifications both the unlimited and the partial exemptions are associated with lower settlement amounts than states without any exemption, although the impact of the partial exemptions is not significant when we eliminate the zero payment cases. These results are consistent with our hypothesis that defendants are advantaged in settlement negotiations when they have the ability to shield assets from a judgment.

Table 17: Settlement Amount Regressions with Both Unlimited and Partial Homestead Exemption Controls

Variables	Settlement Amount	Settlement Amount>0	Ln(settlement Amount)
Unlimited Homestead Exemption	-22,671*** (4,178)	-72,921*** (21,038)	-0.26*** (0.08)
Partial Homestead Exemption	-21,392*** (4,347)	-18,068 (20,627)	-0.40*** (0.08)
Percentage Change in Settlement	-45%	-27%	-23%
Observations	36,442	6,402	6,402

Control variables included in regressions: Year dummies, physician specialty dummies, injury severity dummies, dummy for whether victim was child

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Although somewhat less precise, our estimates including both unlimited and partial homestead exemptions are consistent with the general hypothesis that the ability to shield assets increases defendant doctors bargaining power in settlement negotiation and thus leads doctors to choose lower policy limits, at least in unlimited exemption states.

Clearly, the weakest of our empirical results are those estimated using the insolvent insurer dataset. The limited variation in the unlimited homestead exemption is a concern, as is the relatively large effects we find. Establishing the link between homestead exemptions and policy limits, however, is crucial to validating our theoretical hypothesis. There is only one other dataset, of which we are aware, that includes policy limit information: the 1988 Physicians Practice Costs and Income Survey (1988 PPCIS).

The PPCIS is a cross-sectional survey of physicians conducted for the Health Care Financing Administration. The survey includes responses from 3,505 physicians (a 61% response rate) drawn from a stratified random sample of physicians from the American Medical Association's 1988 Physician Master File. The survey was conducted between July 1989 and March 1990. In addition to its broader sample, a benefit of this dataset is that it is not conditioned on physicians who have been sued. Instead, it is a sample of all physicians.

For our purposes the key questions concern the physician's per occurrence policy limit, the total limit on all events in a year, the premium paid by the physician, and whether the physician had dropped his or her insurance (i.e., whether she has "gone bare"). Table 18 provides summary statistics for the PPCIS.

Table 18: PPCIS Descriptive Statistics

	Mean	Standard Deviation
Per Occurrence Limit	1,060,940	1,109,691
Total Limit	2,638,857	2,298,499
Premium	17,839	28,074
No Coverage	0.01	0.07

If we regress each of these outcomes on our unlimited bankruptcy homestead exemption indicator, we get the results contained in Table 19.

Table 19: PPCIS Regression Results

Variable	Occurrence Policy Limit	Total Policy Limit	Premium	No Coverage
Unlimited Homestead Exemption	-109,075** (42,982)	- (81,841)	1,396 (1,457)	0.013** (0.006)
Percentage Change in Outcome	-10%	-18%	8%	130%
Observations	3,335	3,231	3,400	3,489

Control Variables Include: Physician age, sex dummies, and specialty dummies

***p<0.01, **p<0.05, *p<0.10

This set of results supports our earlier results on the effects of unlimited homestead exemptions on policy limits, and provides a new result that is consistent with the theoretical idea, namely, physicians are more willing to go without medical malpractice insurance when they have the protection of unlimited homestead exemptions. In this dataset, however, we do not find a price effect consistent with our theory. Specifically, we find no statistically significant relationship between the

existence of an unlimited homestead exemption and the price paid for insurance. On net, the results on policy specific outcomes in the insolvent insurer dataset and in the PPCIS data are largely consistent with our theory but some inconsistencies and problems with each dataset provide some room for skepticism. The results on premiums from the Medical Liability Monitor improve confidence somewhat, but more research on this phenomenon is clearly needed.

These results on settlements are in line with those found in the Texas dataset. This suggests that the large size of the haircuts identified in that dataset may result from Texas's unlimited homestead exemption. At a minimum, these results suggest caution is necessary when generalizing from the results found in the TDI data about the medical malpractice insurance market and settlement dynamics in medical malpractice cases.

Although our results are broadly consistent with the substitution theory we put forth above, causal inference in this context is limited given the limited within jurisdiction variation we observe in bankruptcy exemptions. It is possible that the true driving variables in these relationships are merely correlated with the bankruptcy exemptions, but these exemptions themselves do not cause the behavior we observe. While we have advanced a plausible theory consistent with these findings, other as yet unarticulated hypotheses may be even more plausible.

VIII. CONCLUSION

It is a puzzle as to why plaintiffs do not go after defendants' personal assets beyond insurance limits. While for a typical personal injury case, it may be plausible to assume that defendants have few assets, medical malpractice cases are different, given the affluence of physicians. However, the Texas closed claims research suggests that plaintiffs settle for policy limits in those cases too. If that is true, in equilibrium, we should find physicians reducing the amount of insurance that they buy. The degree to which this is a viable strategy, however, is limited by the possibility that plaintiffs will pursue personal assets if limits are too low.

While it has been suggested that the determination of adequate insurance coverage is a question of fairness or morality, an alternate explanation is that plaintiffs are simply being pragmatic. When it is difficult to get at assets, the plaintiffs settle for the insurance policy limits, leading physicians to purchase lower limits in the future. Instead, when it is more difficult to protect assets, plaintiffs are more willing to go after those assets, leading physicians to purchase more insurance coverage.

Using variation in state homestead exemptions in bankruptcy, we

test this hypothesis and find support for it in three separate datasets. In addition to adding some insight into the blood money phenomenon, these results suggest that earlier research focusing on haircuts in Texas medical malpractice cases may not be representative. That is, it is plausible that the large haircuts and low insurance limits found in that work are the result of Texas homestead protection laws, which are qualitatively different than those in most other states. At a minimum, our results suggest that there is something different about Texas when it comes to medical malpractice insurance practices and settlement dynamics. This implies that any extrapolation from work using the TDI data to general conclusions about medical malpractice is problematic. This highlights the importance of using multi-jurisdictional datasets when doing empirical work on medical malpractice.

REFERENCE PRICING: A SMALL AND MIGHTY SOLUTION TO BEND THE HEALTH CARE COST CURVE

SRISHTI MIGLANI*

“Healthcare [is] . . . undoubtedly the most complex of all social systems. Perturbations of complex systems always produce unintended and unexpected consequences, even when all we are doing is eliminating perversion”¹

I. INTRODUCTION

There is no single antidote to the problem of rising health care costs. These costs can be attributed to: the aging population; current payment and delivery structures; administrative burdens; demand for newer medical technology; lack of transparency in price and quality of care; increased health care utilization; insurance benefit design; market consolidation; high per-unit price of medical services; the legal, regulatory, and tax environment; the current structure of the health care workforce; and restrictions on the practice of medicine.² With a multitude of cost drivers, it is naïve to expect a one-size-fits-all solution. Unrealistic expectations can create an unwelcoming atmosphere for strategies that only address one or may be two of the factors that continue to make health care expenditures a greater percentage of our gross domestic product (GDP). To reduce health care costs, we need multiple strategies that, when combined, will address the inefficiencies in health care and lessen the extensive control providers have over prices of medical procedures and services.³

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¹ JOHN GOODMAN, PRICELESS 309 (2012).

² *What is Driving U.S. Health Care Spending: America's Unsustainable Health Care Cost Growth*, BIPARTISAN POLICY CTR. 1, 17 (Sept. 2012), available at <http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20Health%20Care%20Cost%20Drivers%20Brief%20Sept%202012.pdf>.

³ *Trends in Health Care Cost Growth and the Role of the Affordable Care Act*, The White House (Nov. 2013), http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembar go_v2.pdf; Amitabh Chandra, Jonathan Holmes & Jonathan Skinner, *Is This Time*

One strategy that has proven its effectiveness is reference pricing (RP). RP is an insurance benefit design mechanism in which a “reference” price is set for a specified service or procedure, which the health plan sponsor uses to cap its contribution. The beneficiary is responsible for any amount above the defined contribution.⁴ RP seeks to address the significant price variations that exist for medical procedures and services.⁵ RP combines both consumer- and provider-targeted strategies to lower health care costs. On the consumer side, RP originates from the consumer-driven health care movement. It aims to put the consumer’s “skin in the game” to help steer the health care market in the right direction. By giving the insurers some clout, it aims to reduce providers’ market power and control over the prices of medical services. This paper will examine how and why RP shifts risks to consumers and why it is a more effective form of risk sharing than the ones currently being used.

Different? The Slowdown in Healthcare Spending, THE NAT’L BUREAU OF ECON. RESEARCH (2013).

⁴ Francois de Brantes et al., *Reference Pricing and Bundled Payments*, CATALYST FOR PAYMENT REFORM, 1 (Oct. 2013), <http://www.catalyzepaymentreform.org/images/documents/matchtochangemarkets.pdf>.

⁵ For example, the price for a colonoscopy varies from \$800 to \$3,160 in the U.S., which is an approximately a 300 percent price variation. *Colonoscopy*, HEALTHCARE BLUE BOOK (2012), <http://consumerhealthchoices.org/wp-content/uploads/2012/10/Colonoscopy-HCBB.pdf>; see also Elizabeth Rosenthal, *The \$2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures*, N.Y. Times, A1 (June 1, 2013) (discussing the price variation of colonoscopies around the country); The Editorial Board, *The Weird World of Colonoscopy Costs*, N.Y. Times SR10 (June 9, 2013). Castlight Health’s price comparison tool for medical services across the nation shows that a lipid panel costs \$26 in Los Angeles, \$40 in Phoenix, Arizona, \$34 in Las Vegas, Nevada, and \$76 in Salt Lake City, Utah. *Analysis Details Most and Least Expensive Cities for Common Medical Services: Pricing for the Same Medical Services is All Over the Map (Literally), Lipid Panel*, CASTLIGHT HEALTH (Oct. 23, 2014), <http://www.castlighthealth.com/price-variation-map/>. This shows a price variation of 192 percent between the price offered in Los Angeles and Salt Lake City. The average price for a head/brain CT scan in Norfolk, Virginia is \$1,230 with prices ranging from \$218 to \$1,703 and in Richmond, Virginia, the average price is 1,307 with prices ranging from \$218 and \$2,009 (This price variation could be the result of many factors which are not discussed here). *Analysis Details Most and Least Expensive Cities for Common Medical Services: Pricing for the Same Medical Services is All Over the Map (Literally), Head/brain CT scan*, CASTLIGHT HEALTH (Oct. 23, 2014), <http://www.castlighthealth.com/price-variation-map/>.

Although RP's application to procedures and services is a novel concept, RP has been used in the international pharmaceutical market for some time and has achieved success in lowering drug prices. RP's success in reducing overall costs for large U.S. employers that have implemented it in their plan design has laid the groundwork for widespread adoption by other similarly-situated employers. A 2013 survey conducted by Aon Hewitt found that out of more than 1,230 employers surveyed, sixty-two percent planned to adopt RP in the next three to five years.⁶ RP is here to stay; however, its place and role in the current health care system has to be understood and its limitations need to be acknowledged and monitored to ensure it does not adversely impact the quality, access, and affordability of care.

At this early stage, it is important to recognize that RP is not *the* solution to address rising health care costs, it is merely *one* solution. Its success and widespread adoption, however, should be accompanied by cautious optimism. This paper argues that RP can be structured to reap its price-saving potential, but it requires proper regulatory oversight to ensure it does not negatively impact quality, affordability, and access to care. If implemented in a systematic and cautious manner, it can become a useful tool for employers and health plans, especially when combined with bundled payments. Section II of this paper defines RP and explains its origins in the consumer-driven health care movement. Section III highlights RP's application in the international market for pharmaceuticals and domestic market for medical services and procedures. Sections IV explores the short-term and long-term considerations respectively that health plans need to examine and evaluate to implement RP appropriately while balancing the interests of the consumer and cost-saving effects of RP. Section V touches on the possibility of combining RP with bundled payments.

⁶ *Aon Hewitt 2013 Health Care Survey*, AON HEWITT, 13 (June 11, 2014), http://www.aon.com/attachments/human-capital-consulting/2013_Health_Care_Survey.pdf; Another survey conducted by Towers Watson and the National Business Group on Health also showed increased adoption of RP in the coming years. *Reshaping Health Care: Best Performers Leading the Way, 18th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care*, TOWERS WATSON/NAT'L BUS. GRP. ON HEALTH, 20 (2013), <http://www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2013/03/Towers-Watson-NBGH-Employer-Survey-on-Value-in-Purchasing-Health-Care?page=3>.

II. RP AND ITS ORIGINS

A. DEFINITION

RP is a type of defined contribution approach in which the plan sponsor either pays a fixed amount or sets a limit for how much it will pay towards the cost of a health care service.⁷ If a plan member chooses a health care provider or service that costs more than the limit set by the plan sponsor, then the plan member has to pay the difference, which I will refer to as the “gap price.”⁸ The price limit that is set by the plan sponsor is called the “reference price.”⁹ The insurer selects a service or procedure (“reference-priced service” or “reference-price procedure”) for which it wants to set a reference price. It negotiates the cost of a certain service or procedure with the health providers in a defined geographic area. After taking the average of the prices quoted by the providers, the plan sponsor evaluates the quality of services provided by the different providers and decides on a reference price.¹⁰

RP functions like a “reverse-deductible”: the health plan or employer pays the initial part of the allowed cost and the consumer pays the remainder of the charge for the care.¹¹ Once established, the reference

⁷ Paul Fronstin, *Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits*, EMP’T BENEFIT RESEARCH INST., 4 (Apr. 2014), http://www.ebri.org/pdf/briefspdf/ebri_ib_398_apr14.refprcng.pdf. Project Millennial refers to RP as “micro-voucherization” of health care.” Mike Miesen, *The “Micro-Voucherization” of Health Insurance: Can Reference Pricing Bend the Curve?*, PROJECT MILLENNIAL (June 27, 2013), <http://projectmillennial.org/2013/06/27/the-micro-voucherization-of-health-insurance-can-reference-pricing-bend-the-curve/>.

⁸ *Id.*

⁹ Amanda E. Lechner, Rebecca Gourevitch & Paul B. Ginsburg, *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer*, CTR. FOR STUDYING HEALTH SYS. CHANGE, 1 (2013).

¹⁰ *Id.* at 3. Although quality determinations are difficult to conduct, CalPERS’ experiment with RP provides a blueprint for other insurers looking to adopt RP to conduct their quality determinations. Also, it is important to acknowledge that insurers might have an incentive to sacrifice quality for price. But for an insurer looking to lower its costs for certain procedures by adopting RP, it is in the best interests of the insurer to balance quality with price to ensure that its clients do not have to go for repeat procedures or require more than usual follow-up care, which in turn might result in higher overall costs for the insurer.

¹¹ Fronstin, *supra* note 7, at 5.

price becomes the maximum amount the insurer will pay, whether a patient sees an in-network or out-of-network provider. “For out-of-network services, the reference price is identical to a [usual, customary, and reasonable (UCR)]-based ‘allowed amount.’”¹² But for in-network services subject to RP, the reference prices are different than, and essentially an override, of the previously negotiated prices for those services.¹³

RP’s goals are three-fold: (1) to make the consumer an active participant in choosing where to receive the health care services, while being cognizant of the price; (2) to direct the plan members towards low-price providers; and (3) to motivate high-price providers to lower their prices to retain market share.¹⁴ An RP program can achieve its goals with participation from insurers, providers, and consumers and the development of processes that create a transparent and informed atmosphere. First, the plan sponsor has to obtain pricing information from the providers for the negotiated services.¹⁵ Then the health plan sponsor has to inform consumers about the reference prices and quality of care information for the providers. Lastly, the plan sponsor must continuously monitor the reference prices and quality of care to determine which providers to include in its reference-priced network. Although the development of an RP program might appear simple, it comes with several caveats and preconditions for success, all of which will be discussed in Section V.

B. ORIGINS

Catalyst for Payment Reform—an independent, national nonprofit organization that aims to effect change in the health care system—defined reference pricing as a market-based approach that works at the

¹² Jon Gludemans et al., *Reference Pricing and Network Adequacy Standards: Conflict or Concord?* HEALTH AFF. BLOG (Sept. 18, 2014), <http://healthaffairs.org/blog/2014/09/18/reference-pricing-and-network-adequacy-standards-conflict-or-concord/>.

¹³ *Id.*

¹⁴ Fronstin, *supra* note 7, at 5. As I discuss in Section V, putting the onus on consumers has its disadvantages and those have to be recognized and acknowledged in order for RP to become an acceptable and cost-saving tool for the insurance industry.

¹⁵ *How to Make Reference Pricing Work for Consumers*, FAMILIES USA, 5 (June 2014), <http://familiesusa.org/product/how-make-reference-pricing-work-consumers>.

“intersection of consumer engagement and provider contracting.”¹⁶ RP nudges consumers to take an active role in the purchase of health care services, while forcing providers to provide the reference-priced procedure or service at or below the reference price. By “restoring some control to the health care purchasers and prompting providers of health care services to innovate and compete on both price and quality,” RP addresses both the demand and supply side of the health care system.

The health care system has actively reduced the amount of control consumers have over prices, and has made the purchasing process a passive, mindless experience. The consumer-driven health care (CDHC) movement began to put consumers in the driver seat and help regain some of the lost control. CDHC is based on the idea that patients can be better economically-responsible consumers of health care if they are forced to pay a larger share of the health care they consume.¹⁷

Additionally, CDHC is rooted in the belief that moral hazard is one reason for rising health care costs.¹⁸ Moral hazard is “the intangible loss-producing propensities of the individual assured.”¹⁹ In other words, it is the idea that an individual who possesses health insurance tends to consume more medical care than an uninsured individual.

The RAND Health Insurance Experiment (RAND HIE) confirmed the existence of moral hazard. The RAND HIE was a randomized-controlled study designed to answer whether free medical care, when compared to insurance plans with cost-sharing requirements, leads to better health.²⁰ Three thousand five-hundred fifty-eight non-disabled individuals between the ages of fourteen and sixty-one were assigned to a set of insurance plans containing varying levels of cost-sharing for either three or five years. The health effects of these groups were measured and compared.²¹ The study found that “the more people had to pay for medical

¹⁶ *Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead*, CATALYST FOR PAYMENT REFORM, 4 (Nov. 14, 2012), http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf.

¹⁷ James C. Robinson & Paul B. Ginsburg, *Consumer-Driven Health Care: Promise And Performance*, 28 HEALTH AFFAIRS, w272, w278 (2009).

¹⁸ *Id.* at 18.

¹⁹ Mark V. Pauly, *The Economics of Moral Hazard; Comment*, 58 THE AMER. ECON. REVIEW 531, 535 (1968).

²⁰ Robert H. Brook et al., *The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment*, RAND CORP. i., v (1984).

²¹ *Id.* at 3. The people in the cost-sharing group were further divided further into three groups: (1) individual deductible plan: “the family paid 95 percent of the cost of all outpatient care for up to an annual out-of-pocket expenditure of \$150

care, the less they used. Adults who had to share the cost of care made about a third fewer ambulatory visits and were hospitalized about a third less often.”²² While free health care “did not improve the health status across the range of measures or income groups examined, it did confer demonstrable benefits for patients with selected conditions that physicians are trained to manage.”²³ The RAND HIE concluded that there is an inverse relationship between cost sharing and consumption of health care. The increase in consumption of health care is attributable to many factors, including the effect of insurance on reducing the price from market price to zero at the time of service, and the knowledge that an individual’s excess usage is spread over all other purchasers.²⁴ Therefore, the RAND HIE indicated that making the consumer more price-sensitive to the cost of medical services at the point of service can be a solution to the problem of moral hazard.²⁵

Restoring control to the consumer, by itself, is not sufficient to address the power imbalance in our health care system. The other problem that needs to be addressed is the great market power that providers have over the prices of health care services and procedures.²⁶ With big hospital

per person (\$450 per family)”; (2) intermediate coinsurance plan: “the family paid 25 or 50 percent of all health bills each year, inpatient and outpatient, until it had spent 5, 10, or 15 percent of its income or \$1000 (whichever was less)”; or (3) income-related catastrophic plans: “the family paid 95 percent of its health bills up to the same ceiling as in the intermediate plans.” *Id.* The effect of cost-sharing on people’s health was evaluated by looking at the following eleven measures: physical health, role functioning, mental health, social contacts and general health ratings, smoking behavior, weight, cholesterol level, diastolic blood pressure level, visual acuity, and an index of risk of dying from certain risk factors, specifically systolic blood pressure, cholesterol, and smoking habits. *Id.* at vi.

²² *Id.* at 25.

²³ *Id.* at 28.

²⁴ Pauly, *supra* note 19, at 532, 535.

²⁵ Brook et al., *supra* note 20, at 25–28. Other research shows that moral hazard does not explain why all kinds of health care expenditures. See John A. Nyman, Is ‘Moral Hazard’ Inefficient? The Policy Implications Of A New Theory, 23 *Health Affairs* (2007). Nyman argues that moral hazard “makes sense for cosmetic surgery or drugs to improve sexual functioning or designer-style prescription sunglasses, but not for serious treatments such as coronary bypass operations or organ transplants.” *Id.* Therefore, cost sharing mechanisms might not be the solution to reduce health care consumption for those procedures which are not prone to moral hazard. *Id.*

²⁶ Katherine Baicker & Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, 25 *THE J. OF ECON. PERSPECTIVES* 47, 53–54 (2011).

chains and provider groups dominating most local markets, providers are able to get extremely high rates from dominant insurers that feel compelled to pay those high rates to maintain the providers in their networks.²⁷ Additionally, the consolidation of the health care market has increased the monopoly power of the large providers and given them bargaining power over insurers.²⁸ Insurers have little incentive to negotiate lower rates because they know they can pass on the additional costs to consumers and businesses.²⁹ This market failure, resulting from insufficient competition, has nurtured providers' expectations of higher prices, which has, in turn, not only adversely impacted the private insurance sector, but public programs, as well. Diane Archer, Special Counsel and Co-Director of the Health Care for All Project at the Institute for America's Future, explains:

[T]he private health care marketplace will continue to set excessive rates until they are stopped. These exorbitant rates are not only hurting working people, they are also driving up Medicare costs and imposing a massive burden on taxpayers and the federal government. Doctors and hospitals are conditioned to expect higher and higher rates and demand higher payments from public programs.³⁰

So in order to address the market failures that have not been corrected by the market, insurers need to have greater bargaining power to dictate prices. Even though the consolidation and merger wave cannot be stopped, a market in which the providers and insurers can negotiate with approximately the same amount of bargaining power can be created. As an economic matter, the increased competition will hopefully reduce health care prices for consumers and curb the growth of health care spending.³¹ Use of RP in the pharmaceutical, medical procedures, and medical services markets has shown that (1) consumers can be empowered to have greater control over their health care expenditures and (2) insurers and providers

²⁷ Diane Archer, *No Competition: The Price of a Highly Concentrated Health Care Market*, HEALTH AFF. BLOG (Mar. 6, 2013), <http://healthaffairs.org/blog/2013/03/06/no-competition-the-price-of-a-highly-concentrated-health-care-market/>.

²⁸ BIPARTISAN POLICY CTR., *supra* note 2, at 17.

²⁹ *Id.*

³⁰ Diane Archer, *No Competition: The Price Of A Highly Concentrated Health Care Market*, HEALTH AFFAIRS BLOG (March 6, 2013).

³¹ See Lawrence C. Baker et al., *Physician Practice Competition and Prices Paid by Private Insurers for Office Visits*, 312 JAMA 1653 (2014).

can successfully use their respective market power to negotiate and bring health care expenditures down to reasonable levels.

III. APPLICATION OF REFERENCE PRICING

A. PHARMACEUTICAL INDUSTRY

The history of RP in the pharmaceutical sector provides some important insights into its potentials and shortcomings. The use of RP in the pharmaceutical industry has been successful because of the lack of significant heterogeneity between different drugs, and as a result, RP's implementation has been easier. The goal of using RP in the pharmaceutical industry is to "reduce the price of [reference-priced] products either through a relative decrease in the demand for high-priced products (a demand-side approach) or through cuts in drug prices by encouraging self-restraint (a supply-side approach)."³² The only difference in its application in the pharmaceutical industry, compared to the market for procedures and services, is the manner in which the reference price is set for classes of interchangeable drugs.³³ Drugs are grouped by either general referencing or therapeutic referencing.³⁴ Generic referencing applies to only generically equivalent products with the same active ingredient and formulation.³⁵ On the other hand, therapeutic referencing only applies to drugs with different molecules for the same indication.³⁶ A third party payer sets a maximum reimbursement price for a group of

³² Jaume Puig-Junoy, *What is Required to Evaluate the Impact of Pharmaceutical Reference Pricing*, 4 APPLIED HEALTH ECON. AND HEALTH POL'Y 87, 87 (2005).

³³ M.N.G. DUKES ET AL., DRUGS AND MONEY: PRICES, AFFORDABILITY, AND COST CONTAINMENT 85 (7th ed. 2002). "Several options exist [to determine classes of interchangeable drugs]: one can for example limit the system to certain drug categories, usually those representing a major share of a drug budget; one can apply different criteria to the various classes in order to decide on the degree of interchangeability of the drugs within each; and one can choose to introduce the method gradually, experimentally or incrementally, perhaps in order to arrive ultimately at a comprehensive reference system." *Id.* at 86.

³⁴ Patricia M. Danzon & Jonathan D. Ketcham, *Reference Pricing of Pharmaceuticals for Medicare: Evidence from Germany, The Netherlands, and New Zealand*, NAT'L BUREAU OF ECON. RES., 2 (2003), <http://www.nber.org/papers/w10007.pdf>.

³⁵ *Id.* at 3.

³⁶ *Id.*

pharmaceutical products called “clusters.”³⁷ If a patient chooses a drug within the cluster, then he does not have to incur any out-of-pocket costs.³⁸ Otherwise, the patient pays the difference between the reference price and the reimbursement level set for the cluster.³⁹

Before an RP system for drug pricing can be set up, the number and scope of interchangeable drugs have to be defined, the manner in which reimbursement levels for each individual class of drugs will be calculated has to be formulated, a procedure to define the classes of drugs and set reimbursement levels has to be determined, and methods to allow exceptions have to be established.⁴⁰

Some countries determine the reference price by comparing within the domestic or international markets and using the weighted average of the prices of drugs in the group as sold on the domestic market.⁴¹ In a market with substantial generic competition resulting in large price differences among products, the price of the cheapest generic product is used.⁴² Drug classification techniques vary from country to country, and some use a combination of these methods.⁴³ RP policies within a country can, however, vary greatly by insurer.⁴⁴ The Netherlands, for example, uses price comparisons from other countries with similar purchasing power, such as France, Germany, Belgium, and the United Kingdom.⁴⁵ Setting reimbursement levels can be a highly politicized process because of its potential economic impact on the pharmaceutical industry. There is no easy

³⁷ Puig-Junoy, *supra* note 32, at 87.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ M.N.G. DUKES ET AL., *supra* note 33, at 86.

⁴¹ *Id.* at 87.

⁴² *Id.* at 85, 87. The ways in which countries set their reimbursement levels are not limited to these two methods. For example, British Columbia uses the reference drug that is “most cost-effective within its class,” based on scientific evidence accepted by the national regulatory agency, as the standard. *Id.* Netherlands, on the other hand, uses the defined daily dose to set the price for each drug group within the Netherlands’s pharmaceutical reference pricing system. *Id.*

⁴³ *Id.* at 86–87.

⁴⁴ The RP policies vary according to: “equivalence level and criteria; determination of the reference price level; inclusion of patented drugs; therapeutic groups included; system of exemptions from the co-payment associated with RP; level and type of pre-existing co-payment; incentives for doctors and pharmacists; price regulation system; number of producers competing in the market; possibilities of parallel trade; relationship between domestic prices and price regulation in other countries.”

⁴⁵ DUKES ET AL., *supra* note 33, at 88.

solution to take politics out of pharmaceutical price-setting because of the size and power of the pharmaceutical industry. However, a market-based solution that is overseen by a consumer-friendly regulatory framework can work to counteract political forces.

The mechanisms in place to determine exceptions to RP are fundamental to the pharmaceutical RP program. Due to the individualized nature of medicine and health, the drugs in a cluster might not be safe or effective for a certain patient's diagnosis, or the patient's condition might demand a drug that is not reference priced. For example, the RP program implemented by Pharmacare in British Columbia, Canada, allows physicians to apply for a "special authority" exemption from the program when switching drugs would be inadvisable.⁴⁶ So "the physicians can choose not to switch medications for particular patients if side effects or other adverse consequences are expected to result. A physician may present the case to the sick fund, arguing that the patient should be fully refunded, but the patient may ultimately have to pay the difference in order to receive a more expensive drug."⁴⁷ Certain new innovative drugs that do not fit into the existing clusters can be exempted in some cases.⁴⁸ Exemptions work as a relief valve for patients who might have difficulties switching medications.⁴⁹

In countries such as Germany and the Netherlands where reference groups are defined broadly, the heterogeneity of the medications within each group increases.⁵⁰ The effectiveness of the different drugs within a group, despite their interchangeability, varies. Exceptions are allowed to ensure that heterogeneity does not compromise quality. Exceptions have also been granted when there is a concern of patient frailty or if there is a record of previous failure with the treatment.⁵¹

⁴⁶ Paul v. Grootendorst et al., *Impact of Reference-Base Pricing of Nitrates on the Use and Costs of Anti-Anginal Drugs*, 165 CANADIAN MED. ASSOC. J. 1011, 1012 (2001).

⁴⁷ DUKES ET AL., *supra* note 33, at 88.

⁴⁸ Lisa L. Ioannides-Demos et al., *Reference Based Pricing Schemes: Effect on Pharmaceutical Expenditure, Resource Utilisation and Health Outcomes*, 20 PHARMACOECONOMICS 577, 589 (2002).

⁴⁹ *Id.* at 583.

⁵⁰ Stevens Simoens & Sandra de Coster, *Sustaining Generic Medicines Markets in Europe*, RESEARCH CTR. FOR PHARMACEUTICAL CARE AND PHARMACO-ECONOMICS, 68 (2006), http://www.assogenerici.org/articolihome/simoens-report_2006-04.pdf.

⁵¹ Sebastian Schneeweiss et al., *Outcomes of Reference Pricing for Angiotensin-converting-Enzyme Inhibitors*, 346 NEW ENG. J. MED. 822, 823

B. EFFECTS OF PHARMACEUTICAL RP

In the pharmaceutical sector, RP has been instituted in Germany, Denmark, Netherlands, Spain, Italy, British Columbia (Canada), New Zealand, and several other Central and Eastern European countries. Due to the different RP programs in place in each country and other cost-control measures instituted by some countries, it is difficult to compare and generalize the effects of one country's RP program to others. However, data collected from different countries has allowed researchers to understand the short- and long-term effects of RP.

RP has faced criticism and opposition from several groups. The pharmaceutical industry has opposed RP because it does not take into account the "unique advantages" of each new drug that demands a higher reimbursement rate.⁵² Physicians and patients have expressed their fears owing to the unknown health effects that switching a drug might have on the patient.⁵³ Similarly, payers and health care organizations fear increased consumption of health care resources by patients who have been asked to switch to a reference priced drug and who have adverse effects as a result of the switch.⁵⁴ Despite many criticisms,⁵⁵ RP has the potential to become an effective price control tool. Pharmaceutical prices in the classes of drugs where RP is implemented have adjusted to the reference price levels.⁵⁶ RP has motivated physicians to prescribe and patients to consume less expensive options, and the robust exceptions process has provided flexibility for clinical decisionmaking. Also, patient cost sharing has decreased.⁵⁷ More research, however, is needed to better understand the impact of RP on patient outcomes.

RP has emerged as a policy solution to control the costs of U.S.

(2002).

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Some arguments against using RP in the pharmaceutical industry are that it: (1) has unfairly harsh effects on people with lower income who cannot afford a drugs outside the reference-priced clusters, (2) interferes with physician's clinical judgment, (3) requires the physician to devote time to getting exceptions to prescribe non-reference-priced products, (4) can give rise to other health care costs for patients who might react adversely to switching the drug, (5) introduces a financial component to the physician-patient relationship, and (6) promotes inappropriate prescribing. Ioannides-Demos et al., *supra* note 48, at 587.

⁵⁶ DUKES ET AL., *supra* note 33, at 89.

⁵⁷ *Id.*

drug pricing. Its adoption in the domestic market, however, has been extremely limited.⁵⁸ Kroger Co. implemented RP for its prescription medication program in 2012 and, as a result, experienced \$4.3 million in savings that year. The international experience with RP provides an evidence base to estimate its potential benefits for the U.S. pharmaceutical market.⁵⁹ Some health care experts have recommended RP as “an attractive policy strategy” to control costs without negatively affecting medication use or resource consumption.⁶⁰ Economists Panos Kanavos and Uwe Reinhardt, however, have cautioned against overenthusiasm for replicating the RP system in the US:

Given the importance of the U.S. pharmaceutical industry to the nation’s and, indeed, the world’s health care systems, the uncertainty still surrounding the impact of RP on health care, and the political capital that must be spent to implement such a system, U.S. public policymakers probably will want to venture cautiously into this terrain.⁶¹

Factors including (1) centralization of the RP system, (2) breadth of therapeutic clusters of drugs, (3) administrative structures to support such a program, and (4) effect of RP on the quality, cost, and innovation in health care have to be carefully examined before the existing RP systems can be replicated and adopted by the U.S. pharmaceutical market.

C. US HEALTH CARE SERVICES AND PROCEDURES MARKET: CALPERS, KROGER, AND SAFEWAY

The experience with RP in the pharmaceutical industry prompted its adoption by a handful of US purchasers of prescription drugs as well as outpatient, elective procedures. This section will highlight the experience of a large health benefit provider, CalPERS, with RP as applied to hip and

⁵⁸ Joy Li-Yueh Lee et al., *A Systematic Review of Reference Pricing: Implications for US Prescription Drug Spending*, 18 AM. J. OF MANAGED CARE e429, e429 (2012).

⁵⁹ Kate Sullivan, *Reference Pricing Saves Insurance, Patients Money*, FIERCE HEALTH PAYER (Nov. 19, 2013), <http://www.fiercehealthpayer.com/story/reference-pricing-saves-insurers-patients-money/2013-11-19>.

⁶⁰ Li-Yueh et al., *supra* note 58, at e430, e436.

⁶¹ Paul Kanavos & Uwe Reinhardt, *Reference Pricing For Drugs: Is It Compatible With U.S. Health Care?*, 22 HEALTH AFF. 16, 28 (2003).

knee replacement surgeries.

CalPERS is the third largest purchaser of employee health benefits in the nation offering health benefits to more than 1.3 million public employees, retirees, and their families.⁶² CalPERS members include current and retired employees of the state of California and some local governments.⁶³ Employees can choose between three types of plans: (1) preferred provider organizations (PPOs), (2) health maintenance organizations (HMOs), and (3) exclusive provider organizations (EPOs) (limited to members in certain counties in California).⁶⁴ More than two-thirds of CalPERS members are enrolled in an HMO plan, and all plans offer separate Medicare supplemental plans for Medicare eligible members.⁶⁵ Seven different providers—Anthem, Kaiser Permanente, Health Net, Sharp Health Plan, United Healthcare, and CVS Caremark—provide the health plans offered by CalPERS.⁶⁶

Seven-and-a-half percent of CalPERS' total insurance-related costs were related to joint and muscle conditions, and out of those, ten percent

⁶² *Health Benefits Overview*, CalPERS (Apr. 5, 2012), <http://www.calpers.ca.gov/index.jsp?bc=/about/benefits-overview/health/benefits-overview.xml> (last visited Nov. 30, 2014); *Health Benefits*, CalPERS (May 20, 2012), <http://www.calpers.ca.gov/index.jsp?bc=/about/benefits-overview/health/home.xml> (last visited Nov. 30, 2014). CalPERS has a total of 1,678,996 members with 1,104,237 active and inactive members and 574,759 retirees, beneficiaries, and survivors receiving a monthly allowance. *Facts at a Glance*, CalPERS, 1 (Nov. 2014), (<http://www.calpers.ca.gov/eip-docs/about/facts/facts-at-a-glance.pdf>).

⁶³ *Facts at a Glance*, CALPERS, 1 (Nov. 2014), <http://www.calpers.ca.gov/eip-docs/about/facts/facts-at-a-glance.pdf>.

⁶⁴ *Health Benefits Overview*, CALPERS (Apr. 5, 2012), <http://www.calpers.ca.gov/index.jsp?bc=/about/benefits-overview/health/benefits-overview.xml>.

⁶⁵ *Id.*

⁶⁶ Currently, CalPERS offers HMO and PPO plans through Anthem. BlueShield of California offers HMO plans. Health Net offers two HMO plans and a Medicare Advantage plan for CalPERS retirees in the Southern California region. Kaiser offers plans for non-Medicare and Medicare enrollees. Sharp Health Plan offers plans for members in the San Diego County. United Healthcare of California offers and HMO plan to CalPERS members in some counties in Northern and Southern California. CVS serves as the pharmacy benefit provider for the PPO and newly contracted HMO plans. *Presenting the CalPERS 2014 Health Plans Transcript*, CALPERS (Sept. 2014), <http://www.calpers.ca.gov/eip-docs/about/video-web-center/videos/health-benefits/transcript-all-videos.pdf>.

were for routine knee and hip replacements.⁶⁷ Noting major price variations within geographic regions, in 2011, CalPERS teamed up with Anthem to implement RP for its hip and knee replacement procedures covered by Anthem's PPO plans.⁶⁸ Anthem's data showed a "fivefold variation in prices with no measurable difference in quality," with some hospitals charging anywhere from \$15,000 to \$110,000 for hip and knee replacement surgeries.⁶⁹ Relying on this data, while ensuring that sufficient choices were available to CalPERS' members, Anthem set a reference price of \$30,000⁷⁰ for knee and hip replacements.⁷¹ The reference price only applied to the hospital's facility fee and not to physicians' fees or fees for other providers, such as physical therapists.⁷²

Anthem selected forty-one hospitals as "value-based purchasing design" (VBPD) facilities after determining that the prices those facilities offered for knee and hip replacements were less than or equal to \$30,000, the quality of care was acceptable, and in the aggregate the hospitals provided sufficient access to CalPERS members.⁷³ The hospitals classified as non-VBPD facilities charged more than \$30,000 for knee and hip replacements. Members still had to pay the coinsurance amounts for up to a maximum of \$3,000.⁷⁴ If a member chose a facility with a negotiated reference price of less than or equal to \$30,000, he would only have to pay

⁶⁷ Lechner et al., *supra* note 9, at 2.

⁶⁸ *Id.*

⁶⁹ *Id.*; James C. Robinson & Timothy T. Brown, *Increases in Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Surgery*, 32 HEALTH AFF. 1392, 1393 (2013). Lechner et al., *supra* note 9, at 2. "[E]ven when hospitals' quality scores—based on readmission rates, infection rates and the rate of revision of the original surgery—were held constant, the price variation remained." *Id.*

⁷⁰ Medicare on average paid \$14,324 for inpatient knee and hip replacements in 2011. *National and State Summaries of Inpatient Charge Data, FY2011, Microsoft Excel Version*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2011.html>.

⁷¹ *Id.*

⁷² Robinson & Brown, *supra* note 69, at 1393.

⁷³ *Id.* at 1393. "Quality measurements included whether the facility had been accredited by a recognized quality accrediting entity, whether it performed a sufficient number of joint replacement surgeries annually (because surgical volume is associated with positive outcomes), and its scores on the surgical prevention indicators reported by hospitals to the Joint Commission, as well as its participation in the California hospital quality reporting system and its results reported by that system." *Id.*

⁷⁴ Lechner et al., *supra* note 9, at 2.

the capped coinsurance amount for the procedure. But if a member selected a facility with a procedure price of more than \$30,000, then he would be responsible for the gap price in addition to the capped coinsurance amount.⁷⁵

As a result of the RP, CalPERS saved \$2.8 million in the first year of implementation and patient cost-sharing decreased by approximately \$300,000.⁷⁶ An extended examination of the program from 2008 to 2012 and comparison with non-CalPERS Anthem members showed that the RP program incentivized patients to choose lower-priced facilities.⁷⁷ Figure 1 shows that in 2010, before the RP program began, forty-eight percent of the patients chose non-VBPD facilities for hip and knee replacement surgeries, whereas that number decreased to thirty-seven percent in 2011 after the RP program began.⁷⁸ Also, the number of CalPERS members choosing VBPD facilities increased from fifty-two to sixty-three percent from 2010 to 2011.⁷⁹ This increase was not observed for the non-CalPERS Anthem population.⁸⁰ Controlling for other confounding factors, the analysis concluded that in 2011, RP itself caused a 28.5 percent increase in the volume for VBPD facilities among CalPERS enrollees.⁸¹

⁷⁵ *Id.* For example, a member with a ten percent coinsurance who got a hip replacement at a facility charging \$29,000 for the procedure would pay \$2,900. But, if the same member chose a facility that charged \$32,000 for the hip replacement, he would have to pay \$3,000 coinsurance amount (ten percent of 32,000 would be \$3,200, but that amount is capped at \$3,000). Also, the member would be responsible for the difference between the reference price (\$30,000) and the price the facility charged (\$32,000), which is \$2,000. So the member will pay a total of \$5,000.

⁷⁶ Lechner et al., *supra* note 9, at 3.

⁷⁷ *Id.*

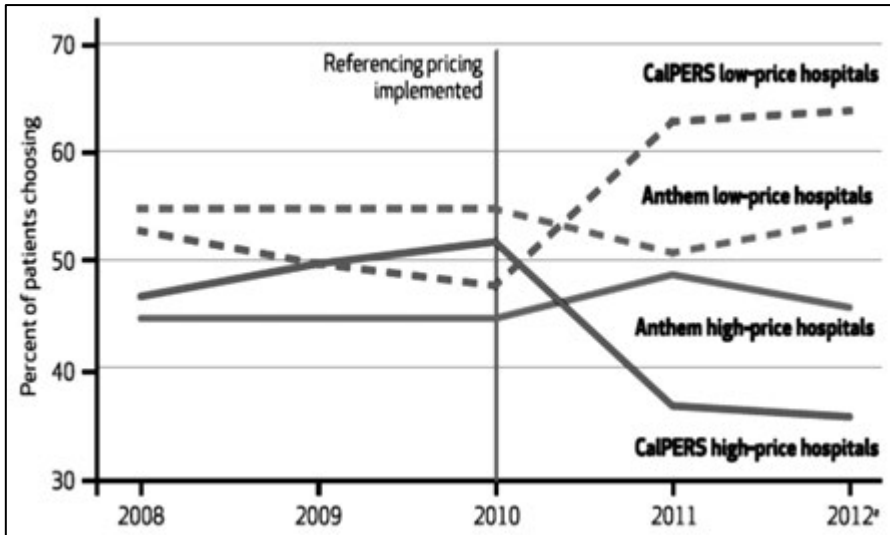
⁷⁸ Robinson & Brown, *supra* note 69, at 1393.

⁷⁹ *Id.* at 1393–94.

⁸⁰ *Id.* at 1394.

⁸¹ *Id.* at 1395.

Figure 1: Patients Choosing non-VBPD (high price) or VBPD (low-price) Hospitals for Hip or Knee Replacement Surgery, 2008–2012⁸²



The RP program also had an effect on hospital prices. Figure 2 shows a comparison between the prices charged by VBPD and non-VBPD hospitals for knee and hip replacement surgeries from 2008 to 2012. After the implementation of the RP program in 2011, the average price charged by the VBPD hospitals decreased by 5.6 percent and then increased slightly. But, the prices charged by non-VBPD hospitals decreased by 34.3 percent in 2011.⁸³ Although, in 2011, half of the non-VBPD hospitals continued to increase their prices and half of them reduced prices, the average price reductions were “more than twice as large for the facilities that reduced the prices (\$11,048 per patient) [when compared to] the average price increase for those that increased prices (\$4,097).”⁸⁴ Overall, hospitals decreased the prices they charged to CalPERS enrollees for hip and knee replacement procedures.⁸⁵

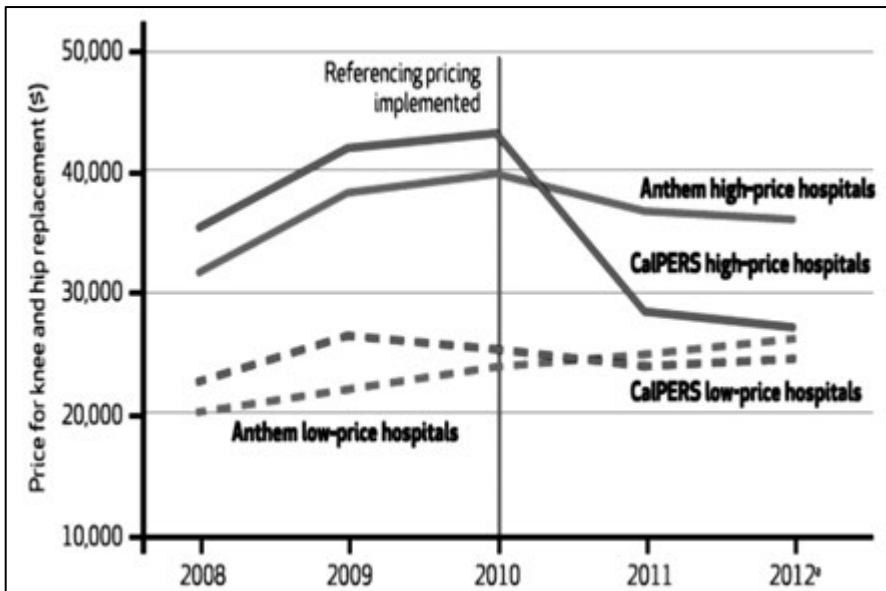
⁸² *Id.*

⁸³ Robinson & Brown, *supra* note 69, at 1395.

⁸⁴ *Id.*

⁸⁵ *Id.*

Figure 2: Prices Paid for Knee and Hip Replacement Surgery in VBPD (low-price) and non-VBPD (high-price) California Hospitals, 2008–2012⁸⁶



In addition to the cost savings to both CalPERS and its members, there were positive outcomes for patients' health. Furthermore, CalPERS did not observe any evidence of adverse health or quality outcomes for patients participating in the RP program.⁸⁷ The thirty-day general complication and infection rates and ninety-day follow-up admission rates were compared for CalPERS members who got hip and knee replacements in the year before and after the implementation of RP. The analysis found no significant difference in quality outcomes between the two years.⁸⁸ Furthermore, CalPERS members who had their hip or knee replacement surgeries at a VBPD hospital had “nearly equal or better outcomes” on the infection and readmission measures when compared with members who used non-VBPD hospitals.⁸⁹ After CalPERS's success with hip and knee replacements, it extended the program to ambulatory surgical and imaging

⁸⁶ *Id.* at 1396.

⁸⁷ *Id.* at 1393.

⁸⁸ Robinson & Brown, *supra* note 69, at 1393.

⁸⁹ *Id.*

procedures, including cataract surgeries, knee arthroscopies, and colonoscopies.⁹⁰ Results from the evaluation of RP's application to these additional procedures are not yet available.

With the application of RP to knee and hip replacements, CalPERS realized modest savings. Even though it did not significantly lower CalPERS' overall costs, it provided a solution to reduce the costs of certain expensive, highly price-variable medical procedures. In addition, RP helped steer the health care market in the right direction when non-VBPD hospitals significantly reduced their prices. Granted, some VBPD hospitals raised their prices slightly, but CalPERS and its employees still realized overall savings. Overall, the RP program as implemented by CalPERS was a win-win-win combination resulting in cost-savings for the employer, price reduction by the hospitals, and benefits for the employees in terms of lower cost sharing and greater accountability for their health care costs.

Other large employers have also adopted RP as a strategy to lower costs of their self-insured plans. Kroger Co., one of the world's largest retailers, with 375,000 employees, collaborated with WellPoint to set up its own RP program for radiology services and prescription medications.⁹¹ The radiology program includes services such as abdomen computerized tomography (CT), pelvic CT, chest CT, brain CT, and spine magnetic resonance imaging (MRI).⁹² Using two years of health claims data, the company set a reference price for those services while ensuring adequate access for its employees.⁹³ It set a reference price of \$800 for certain imaging scans in ten of the thirty-one states where it operates.⁹⁴

⁹⁰ Lechner et al., *supra* note 9, at 5; The Self-Insured School of California has also set up its own RP program. *Id.* at 5. One of the respondents of that program stated, "Before this program went into place, most members just knew how much their copays were and how much their deductible was. Some members will look at the EOB [explanation of benefits], and they are shocked [at the prices hospitals charge], but most people don't pay attention to that information. This initiative brought to light the fact that there are huge differences in prices for procedures, and you can get most procedures done affordably without sacrificing quality." *Id.*

⁹¹ Kroger calls its RP program "target pricing program." For consistency, I will refer to it as RP. Letter from Theresa Monti, Vice President, Corporate Total Rewards, Kroger Co., to Phyllis C. Borzi, Assistant Secretary of Labor, Employee Benefits Security Administration (Aug. 1, 2014), <http://www.dol.gov/ebsa/pdf/faq-xix-0017.pdf>.

⁹² *Id.* at 3.

⁹³ *Id.* at 3-4.

⁹⁴ Alex Nussbaum, *Surgery Cost Caps Save Pension Fund 19% Without Hurting Health*, BLOOMBERG (June 23, 2013, 11:00 PM),

Similarly, Safeway, a national grocery store chain with 150,000 employees in separate health plans, also implemented its own RP program.⁹⁵ Safeway, like CalPERS, also noticed significant price variations for colonoscopies within certain geographic markets.⁹⁶ In San Francisco, the prices for colonoscopies varied from \$848 to \$5,984.⁹⁷ Safeway implemented a pilot program in which it set the reference price for colonoscopies at \$1,500. This only included the facility fee; the physicians were paid according to a uniform fee schedule.⁹⁸ After the success of its program, Safeway extended RP to arthroscopy, hernia repair, gall bladder removal, cardiac catheterization and laboratory tests, and other medical procedures.⁹⁹ Kroger Co., along with CalPERS and Safeway, have pioneered the application of RP and successfully controlled their rising health care costs by targeting certain medical services and procedures which suffer from great price variation.

IV. SHORT AND LONG-TERM CONSIDERATIONS

A. SHORT-TERM CONSIDERATIONS

With the success of RP's application to medical services and procedures, large employers now have an evidence base which they can rely on when implementing their own RP programs. Although implementing RP can require some initial investment, the long-term savings and the benefits of implementing a change in the value system of employees can be enormous. However, RP's success is contingent on careful weighing of short- and long-term considerations.

<http://www.bloomberg.com/news/2013-06-24/surgery-cost-caps-save-pension-fund-19-without-hurting-health.html>.

⁹⁵ James C. Robinson & Kimberly MacPherson, *Payers Test Reference Pricing And Centers Of Excellence To Steer Patients To Low-Price And High-Quality Providers*, 31 HEALTH AFF. 2028, 2032 (2012); In 2008, before the colonoscopy RP program, Safeway implemented RP for pharmaceuticals. Lechner et al., *supra* note 9, at 5.

⁹⁶ Robinson & MacPherson, *supra* note 95, at 2032.

⁹⁷ *Id.*

⁹⁸ *Id.* The pilot was extended to other markets where the RP was set at \$1,250.

⁹⁹ Robinson & MacPherson, *supra* note 95, at 2032–33. 451 of the 847 laboratory tests covered by Safeway's benefit plan have been subject to RP. *Id.* at 2033.

1. Ensuring Network Adequacy

Maintaining proper network adequacy is a critical area that should be considered by health plans looking to adopt RP. RP programs should not be a subterfuge, allowing insurers to create the “appearance of maintaining a broad network.”¹⁰⁰ By reducing the amount that is fully reimbursable for a certain procedure, an insurer can disincentivize consumers from choosing the in-network providers that charge more than the reference price. In essence, an insurer can create smaller networks within the larger in-network provider sphere

Network adequacy is generally defined by states as “a health plan’s ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as other health care services included under the terms of the contract.”¹⁰¹ RP programs can blur the line between in-network and out-of-network providers and, therefore, make it difficult to ascertain network size. By treating in-reference priced providers as out-of-network providers, RP creates mini networks within the already established network. A provider that negotiates with the insurer to be considered in-network can be treated as out-of-network for a reference-priced procedure while still being in-network for other procedures and services. It is important to note that so far, only large employers with self-insured plans have implemented RP. Self-insured plans are not subject to state regulations relating to health insurance¹⁰² and “there are no federal network adequacy standards for large group health plans and no state or federal network adequacy standards for self-insured group health plans.”¹⁰³ These mini networks-within-networks for reference priced procedures are generally immune from network adequacy requirements.

Glaudemans et al. raise concerns with the unregulated nature of network adequacy for self-insured plans implementing RP.¹⁰⁴ First, RP programs have the potential to confuse customers since they have to

¹⁰⁰ Letter from Robert Restuccia, *available at* <https://www.dol.gov/ebsa/pdf/faq-xix-0012.pdf>.

¹⁰¹ Sally McCarthy & Max Farris, *ACA Implications for State Network Adequacy Standards*, ROBERT WOOD JOHNSON FOUND. (2013), *available at* <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/08/aca-implications-for-state-network-adequacy-standards.html>.

¹⁰² FURROW ET AL., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 696 (7th ed. 2013).

¹⁰³ Glaudemans et al., *supra* note 12.

¹⁰⁴ *Id.*

navigate the in-network and out-of-network lists and also the referenced-priced provider list.¹⁰⁵ This confusion can hamper customers' ability to access medical services, and the access problem can be worsened if consumers receive insufficient information.¹⁰⁶ Second, "[p]lans may seek to develop broad networks with seemingly generous payment rates, only to subsequently adopt aggressive reference pricing structures that render the seemingly generous contracts moot."¹⁰⁷ This strategy can undermine consumers' ability to choose a plan that includes their regular providers and create uncertainty as to which provider is in-network or out-of-network. Lastly, there is concern that the traditional methods of assessing network adequacy based on "ratios, totals, and drive times"—number of primary care providers in a given population or service area, appropriate mix of community hospitals and tertiary care facilities, and distance a patient has to drive to access a particular specialty—might not be adequate to assess the adequacy of mini RP networks.

Having sufficient providers participate and become a part of the reference-priced networks is not only critical for consumer choice but also for RP's mainstream adoption in to the health care system.

2. Quality of Care

Quality of care has to be carefully balanced when finding providers to participate in RP programs. The fear is that, in choosing a provider for the RP program, an insurer's choice will be based on whether a provider offers a price at or below the reference price without considering the quality of care provided. Measuring quality of care¹⁰⁸ is not an easy task,¹⁰⁹

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ "High-quality care" has been defined by the Institute of Medicine (IOM) as "care that is safe, effective, patient-centered, timely, efficient, and equitable (with no disparities between racial or ethnic group)." Christina Bielaszka-DuVernay, *Improving Quality and Safety*, 33 HEALTH AFF., 1, 2 (2011).

¹⁰⁹ Robert H. Brook et al., *Defining and Measuring Quality of Care: A Perspective from US Researchers*, 12 INT. J. FOR QUALITY IN HEALTH CARE 281, 281 (2000); Elizabeth A. McGlynn, *Six Challenges in Measuring the Quality of Health Care*, 16 HEALTH AFF. 7, 7 (1997) ("patients, providers, and payers each define quality differently, which translates into different expectations of the health care system and thus differing evaluations of its quality"); *Measuring and Improving Quality of Care: A Report From the American Heart Association/American College of Cardiology First Scientific Forum on Assessment*

Although measuring quality in health care is not a new endeavor, the development of proper, effective measures has been slow.¹¹⁰

The concern about quality has to be addressed on two levels: (1) in selecting procedures for which price variation is not related to variation in quality, and (2) in measuring quality of providers within the reference-priced network. For example, in deciding the connection between price and quality for hip and knee replacement surgeries, CalPERS examined the difference in quality scores for hospitals charging prices ranging from \$15,000 to \$110,000 and looked at the hospitals' readmission rates, infection rates, and rates of revision of the original surgery.¹¹¹ Also, CalPERS monitored the quality of providers within the reference-priced network. It looked at the reference-priced "hospital's quality based on accreditation by recognized quality accrediting entities, whether the hospital performed a sufficient number of joint replacement surgeries annually, and the hospital's scores on surgical prevention indicators, as well as participation in California's hospital quality reporting systems."¹¹² This provided CalPERS with the means to measure quality variation for purposes of RP among the broader provider base and within the reference price network to ensure that the quality of care its members were receiving was not inadequate and would not negatively impact its members' health. CALPERS' experience can serve as a starting point in thinking about

of Healthcare Quality in Cardiovascular Disease and Stroke, AM. HEART ASS'N 1484–1485 (2000), available at <http://circ.ahajournals.org/content/101/12/1483.full.pdf+html> (Defining the methodological challenges in measuring health care quality).

¹¹⁰ The National Committee for Quality Insurance's Healthcare Effectiveness and Data Information Set Standards (HEDIS) are used by health plans to track quality and services. Christina Bielaszka-DuVernay, *supra* note 108, at 2. The National Quality Forum, a nonprofit organization formed at the recommendation of the President's Advisory Commission on Consumer Protection and Quality in Health Care Industry, has "certified 34 separate health care practices and procedures to be effective in reducing the occurrence of adverse events." *Id.* The Joint Commission, a private nonprofit organization, accredits hospitals and other health care organizations. *Id.* For a discussion of the improvements to be made in the area of quality measurements in health care, see *Improving Health Care Quality: The Path Forward, Hearing before the Senate Comm. on Finance*, 113th Cong. 1 (2013) (statement of Mark B. McClellan, Dir., Engelberg Ctr. for Health Care Reform, Brookings Inst.).

¹¹¹ Letter from Robert Restuccia, *supra* note 100; James Robinson & Kimberly MacPherson., *Payers Test Reference Pricing And Centers Of Excellence To Steer Patients To Low-Price And High-Quality Providers*, 31 HEALTH AFFAIRS (2012).

¹¹² *Id.*

effective and efficient ways of measuring and monitoring quality in RP programs.

3. Adequacy of the Reference Price

The reference price should be set at a level that encourages provider participation, does not limit access to care, and allows the issuer to attain cost savings.¹¹³ But setting the price inappropriately low can have the following adverse consequences: (1) the consumer will pay more out-of-pocket for the procedures above the reference price; (2) with time, hospitals will lower their price and join the RP program; (3) participating hospitals will increase the prices for other services and procedures not subject to RP; (4) there will be “consolidation among providers, which will increase negotiating power among providers”; or (5) RP programs will fail due to insufficient provider participation and increased patient cost-sharing.¹¹⁴ If the reference price is set too high, it will provide an abundance of choices for the consumer but it will not lead to maximization of savings, as desired by the plan sponsor.¹¹⁵ Community Catalyst suggested that the reference price should be “set high enough so that the price reflects what the majority of high-quality providers within that region charge for care.”¹¹⁶ With these limitations and with the great variation in prices for procedures around the nation in mind, prices for RP programs for services and procedures have to be set locally or regionally.¹¹⁷ Some organizations have even warned against setting a reference price across states because providers will negotiate higher prices in regions where they have significant market power.¹¹⁸ Reference prices will be a critical factor in ensuring a meaningful choice for the consumers and RP’s success in the long term.

4. Consumer Education

Consumer education is the keystone of RP’s success because it ensures that participants have the necessary tools to make informed

¹¹³ Paul Fronstin, *supra* note 7, at 10.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ Letter from Robert Restuccia, *supra* note 100. Community Catalyst is a non-profit consumer advocacy organization.

¹¹⁷ *Id.*

¹¹⁸ FAMILIES USA, *supra* note 15, at 7.

decisions when choosing providers for procedures and services subject to RP. For example, before an insured consumer enters into a plan, he should be informed by the insurer of the procedures subject to RP, the reference price for each procedure, the amount in excess of the reference price that does not fall under the insurer's definition of out-of-pocket costs, and what does and does not count towards the annual out-of-pocket maximums.¹¹⁹ Furthermore, before a consumer receives a service that is subject to RP, the insurer should inform him as to which providers charge at or below the reference price,¹²⁰ the reference price for that service and the insured's obligation if a higher priced provider is chosen, and guidance on requesting an exception from the RP program.¹²¹

5. Exceptions

Allowing exceptions prevents consumers from being subject to RP if they do not have the time or ability to make a price-sensitive decision, and also provides flexibility to the RP program to accommodate the individualized nature of health and sickness. Consumers suffering from certain serious conditions might require referenced-priced procedures and services from providers who are not in the reference-priced network. Providers treating patients with chronic conditions need to be involved in the management and treatment of the chronic condition in order to ensure continuity of care. Exceptions should also be allowed for patients whose health conditions require services of a non-reference-priced provider or specialist.

Additionally, RP programs should allow for exceptions if a patient's health needs or circumstances require him to see a non-reference priced provider for a reference-priced procedure. An exceptions process should include a case-by-case evaluation with fair outcomes. The specific

¹¹⁹ Letter from Yvonne Clearwater, Acting Deputy Dir. Health Products, Illinois Dep't of Ins., to U.S. Dep'ts of Labor, Health and Human Servs, and Treasury (July 30, 2014), <http://www.dol.gov/ebsa/pdf/faq-xix-0009.pdf>; Letter from Edward Potanka, Vice President Chief Counsel, Legal and Pub. Affairs, Cigna, to Emp. Benefits Sec. Admin., U.S. Dep't of Labor (Aug. 1, 2014), <http://www.dol.gov/ebsa/pdf/faq-xix-0027.pdf>.

¹²⁰ Letter from Karin Feldman, Benefits and Social Ins. Policy Specialist, Am. Fed'n of Labor and Congress Indus. Org. to Office of Health Plan Standards and Compliance Assistance, Emp. Benefits Sec. Admin., U.S. Dep't of Labor (Aug. 1, 2014), <http://www.dol.gov/ebsa/pdf/faq-xix-0031.pdf>.

¹²¹ Letter from R. Douglas Lemmerman, *available at* <https://www.dol.gov/ebsa/pdf/1210-AB52-0076.pdf>.

situations that will give rise to the granting of an exception might be different under each program. For example, American Cancer Society (ACS) and Families USA suggested that exceptions should be available in situations in which requiring the consumer to choose a provider within the reference price would harm the consumer's care coordination,¹²² cause the consumer to travel a great distance to go to that provider, or involve long wait times for the consumer.¹²³ The individualized nature of health and health care requires that RP programs incorporate a process by which a patient's case can be evaluated on an individual basis.

Additionally, exceptions should be granted for a consumer receiving an emergency procedure and who might not have the time or ability to browse reference-priced providers.¹²⁴ That is why CalPERS excluded any emergency knee or hip replacement surgeries received by an employee from the restrictions of the RP program.¹²⁵ Lastly, exceptions should be considered when a consumer's health conditions or complications require more costly care services and procedures that are not provided by every healthcare facility or provider.¹²⁶ For many consumers, especially with certain co-morbidities or serious health conditions, continuity of care trumps cost savings.

B. LONG-TERM CONSIDERATIONS

Besides the concerns that the current RP programs raise, there are many larger concerns that need to be addressed when deciding the long-term viability of RP. RP is a blunt mechanism for cutting health care costs that needs to be carefully implemented with a proper evaluation of both short- and long-term considerations.

¹²² Letter from Lydia Mitts, Senior Policy Analyst, Families USA, to Sec'y Jack Lew, U.S. Dep't of Treasury, Sec'y Thomas E. Perez, U.S. Dep't of Labor, and Sec'y Sylvia Matthews Burwell, U.S. Dep't of Health and Human Servs. (July 31, 2014), <http://www.dol.gov/ebsa/pdf/faq-xix-0014.pdf>.

¹²³ Letter from R. Douglas Lemmerman, *supra* note 121.

¹²⁴ Hau Liu, *Closing the Gap: Reducing Price Variance in Health Care with Reference-Based Pricing*, CASTLIGHT HEALTH, 6 (July 2012), http://content.castlighthealth.com/rs/castlighthealth/images/RBP-White-Paper_July-2012_draft4.pdf.

¹²⁵ Lechner et al., *supra* note 9, at 2.

¹²⁶ Paul Fronstin, *supra* note 7, at 8.

1. Rewarding Efficiency and Quality

Even though the main goal of RP is to reduce and control the rising cost of health care services, it does not adequately focus on efficiency. After a reference price has been set, there is a perverse incentive for hospitals already charging below the reference price to increase their prices to match the reference price. This phenomenon was seen in the CalPERS experiment where the VBPD hospitals that were already charging less than \$30,000 for hip and knee replacements raised their prices after the RP program was put in place.¹²⁷ RP will, however, motivate hospitals charging more than the reference price to bring down their prices. As Amanda Lechner et al. stated, RP “is a ‘blunt instrument’ that excludes providers with the highest prices but does not reward extremely efficient providers.”¹²⁸ This phenomenon is similar to what has been observed in the Medicare Prospective Payment System (PPS). Under the PPS, provider reimbursement is based on paying the same rate for the same services by categorizing health care services into diagnostic related groups (DRGs).¹²⁹ Karen Davis and Stuart Guterman explained:

Such a system of payment rewards those hospitals and physicians that efficiently produce those units of care (hospital stays and physicians’ visits and procedures) because they can pocket any difference between the fixed price they are paid for each unit and the amount it costs them to produce it. The main disadvantage of this approach is that although it rewards providers for producing each

¹²⁷ Robinson & Brown, *supra* note 69, at 1396; “The benefit design does not reward the provider that charges \$15,000 any more than the provider that charges \$30,000.” Lechner et al., *supra* note 9, at 8.

¹²⁸ Lechner et al., *supra* note 9, at 8.

¹²⁹ “The DRG payment rates cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services. The CMS creates a rate of payment based on the “average” cost to deliver care (bundled services) to a patient with a particular disease. The DRG rates do not expressly include direct medical education costs, outpatient services, or services covered by Medicare Part B . . . The DRGs classify all human diseases according to the affected organ system, surgical procedures performed on patients, morbidity, and sex of the patient.” *Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated*, OFFICE OF INSPECTOR GEN., DEP’T OF HEALTH AND HUMAN SERVS., 5 (Aug. 2001), <https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf>.

unit of care efficiently, it also rewards providers for producing a greater quantity of services, even if the same or better patient outcomes could be achieved with fewer services or a less expensive combination of services. As a result, Medicare's payment policy still does not encourage efficiency in its overall provision of care over time or over an episode of illness.¹³⁰

In the PPS, payments do not reward efficiency but instead pay for the care provided. Similarly, in an RP program, once the reference price is set, already-efficient hospitals charging below the reference price have no incentive to keep costs at that level, or try to become even more efficient, because of the reference price guarantee. Additionally, the outcome of the procedure or quality of care provided does not change the level of payment that the hospital will receive for a reference-priced procedure. The price-saving potential of RP should be carefully weighed against efficiency and quality of care.

2. Preventing Disruption of Continuity of Care

RP's effect on continuity of care is especially critical for patients with chronic conditions. Although there are multiple definitions of continuity of care, it has several accepted dimensions: informational continuity, chronological or longitudinal continuity, geographic continuity, interdisciplinary continuity, interdisciplinary or team-based continuity, and family continuity.¹³¹ RP brings into question informational continuity, chronological or longitudinal continuity, and team-based continuity.

Informational continuity is defined as "the availability of patient information to providers throughout a healthcare system."¹³² With slower than expected acceptance and use of electronic health record systems

¹³⁰ Karen Davis & Stuart Guterman, *Rewarding Excellence and Efficiency in Medicare Payments*, 85 THE MILIBANK Q. 449, 451 (2007).

¹³¹ John W. Saultz, *Defining and Measuring Interpersonal Continuity of Care*, 1 ANNALS OF FAM. MED. 134, 136 (2003). (Geographic continuity is defined as "care that is provided with continuity regardless of the location of the patient (office, home, hospital, etc.)." Interpersonal continuity refers to a "special type of longitudinal continuity in which an ongoing personal relationship between the patient and care provider is characterized by personal trust and responsibility").

¹³² Gina Agarwal & Valorie A Crooks, *The Nature of Informational Continuity of Care in General Practice*, 58 BRIT. J. OF GEN. PRAC. e1, e1 (2008).

within hospitals,¹³³ it is difficult to imagine how the flow of information between reference-priced providers and a patient's regular providers will allow continuity of care. Chronological or longitudinal continuity is defined as "a patient seeing the same provider over time and developing a relationship based upon trust."¹³⁴ Since laboratory and imaging services—some of the common services subjected to RP—are generally not performed by a patient's usual physician, the disruption of care might not be an issue if RP is applied to those services. For hip and knee replacement surgeries, however, the relationship of trust that a patient establishes with his or her provider before the surgery is essential to a patient's decision when and where to get the surgery. In addition, a patient's care can be disrupted when he receives the pre-surgery care and the surgery itself from different providers who might not be able to effectively share the patient's information. This could have harmful effects on the patient's health and post-surgery care. The same problem exists with the lack of team-based continuity. Team-based continuity is defined as "care that allows previous knowledge of the patient to be present even when the patient requires a wide range of services spanning the traditional medical specialties."¹³⁵ If a the patient's usual provider is not part of the same team as the reference-priced provider who performs the surgery that causes a disruption in team-based continuity.

These scales of continuity of care play an even more significant role for patients with chronic conditions and the elderly. For example, a person suffering from Ulcerative Colitis would prefer that his regular gastroenterologist performs the colonoscopy to check his colon and look for any signs of tumor formation. If this specialist does not work for a reference-priced hospital, then the patient will have to make an unfair choice between having his specialist perform the colonoscopy and paying the gap price or choosing a reference-priced provider and disrupting the care and management of his chronic condition. Continuity of care is essential for the management of chronic conditions and RP can hinder that

¹³³ Only twelve percent of the 2,952 hospitals surveyed "had instituted electronic physicians' notes across all units," and only seventeen percent of the hospitals has "computerized provider-order entry for medications was reported as having been implemented across all clinic units." Ashish K. Jha et al., *Use of Electronic Health Records in U.S. Hospitals*, 360 NEW ENG. J. OF MED. 1628, 1631 (2009).

¹³⁴ Paul Beattie et al., *Longitudinal Continuity of Care Is Associated With High Patient Satisfaction With Physical Therapy*, 85 PHYSICAL THERAPY 1046, 1047 (2005).

¹³⁵ John Saultz, *supra* note 131, at 136.

flow if RP is blindly applied to all categories of patients.

A study conducted by Mainous III and Gill found that continuity of care with a clinician decreases the likelihood of future hospitalizations.¹³⁶ Also, continuity with a provider has been found to be more important than continuity with a health care site.¹³⁷ Patients with a continuous relationship with their physicians are “more satisfied with their care, are more likely to take medications correctly, and are more likely to have problems identified by their physician.”¹³⁸ Besides these benefits, continuity of care is significantly associated with decreased emergency department visits. Having continuity of care is important for patients, especially those suffering from chronic conditions,¹³⁹ and forcing consumers to obtain procedures from reference-priced providers, if different from their regular providers, might compromise the continuity of care their illness demands. Health plans looking to adopt RP should consider whether and to what extent continuity of care will be affected for procedures and services subject to RP and how to prevent patients with chronic health conditions from disruption of care.

3. Improving Cost Savings

RP can compromise continuity and efficiency of care for cost savings. But, if those cost savings are insignificant, they do not provide an incentive to insurers to use such a harsh cost-cutting tool and spend the time, effort, and money to institute an RP program. A recent study conducted by the Center for Studying Health System Change (CSHSC) showed that RP for “shoppable health care services” will only lead to

¹³⁶ Arch G. Mainous III & James M. Gill, *The Importance of Continuity of Care in the Likelihood of Future Hospitalization: Is Site of Care Equivalent to a Primary Clinician?*, 88 AM. J. OF PUB. HEALTH 1539, 1540 (1998); “An explanation for this finding is that continuity with a physician leads to increased knowledge and trust between a patient and a physician. This increased knowledge and trust may make it easier for the physician to manage medical problems in the office or over the telephone and thereby avoid hospitalization.” James M. Gill et al., *The Effect of Continuity of Care on Emergency Department Use*, 9 ARCHIVES OF FAM. MED. 333, 333 (2000).

¹³⁷ Mainous III & Gill, *supra* note 136, at 1540.

¹³⁸ Gill et al., *supra* note 136, at 333.

¹³⁹ See generally Anton R. Miller et al., *Continuity of Care for Children with Complex Chronic Health Conditions: Parents' Perspectives*, 9 BMC HEALTH SERVS. RES. 1, 1 (2009).

modest savings.¹⁴⁰ The study quantified the share of spending attributable to “shoppable health care services” and simulated the effect of RP on those services.¹⁴¹ The study analyzed RP for both inpatient and outpatient services using 2011 enrollment and claims data from 528,000 active and retired nonelderly U.S. autoworkers and their dependents.¹⁴² The study was limited to nineteen metropolitan markets in the Midwest, each with at least 4,000 enrollees.¹⁴³

While imaging and laboratory tests accounted for 13.9 percent of total health care spending in the claims data, the savings, after applying RP to the shoppable imaging and laboratory services, accounted for only 1.9 percent of total spending.¹⁴⁴ Savings for other shoppable services did not look too promising: inpatient hospital stays: 0.6 percent; outpatient hospital services/ambulatory procedures and physician office visits: 2.1 percent; uncomplicated hip and knee replacements: 0.2 percent; and all other shoppable services: 4.8 percent.¹⁴⁵ Overall, regardless of the percentage of total spending that the procedure accounted for, the resulting savings, after applying RP to those procedures, were minimal.¹⁴⁶ Generalizing from these findings, the authors of the study cautioned against drawing broad conclusions from CalPERS’ success with RP because even though there was “a dramatic percentage decline in prices and spending on knee and hip replacements,” there was only “an extremely small percentage decline in total spending.”¹⁴⁷ Despite the capped contribution approach for highly price-variable procedures, RP might not have a significant impact on the health plan sponsors’ total spending. However, the study did not discourage

¹⁴⁰ Chapin White & Megan Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*, NAT’L INST. FOR HEALTH CARE REFORM, 6 (2014), file:///C:/Users/Srishti/Downloads/Research_Brief_No._18%20(2).pdf. A “shoppable health care service” was defined as must typically be scheduled in advance, there must be more than one provider in a market that can perform the service, and there has to be price data available for the different providers,” and for which patients would have information about the quality of providers. *Id.* at 2.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 6.

¹⁴⁵ White & Eguchi, *supra* note 140, at 6.

¹⁴⁶ *Id.* Percentages of total spending by types of procedures were as follows: Inpatient procedures: 6.4 percent; outpatient hospital services/ambulatory procedures and physician office visits: eighteen percent; and all other shoppable services: 35.3 percent.

¹⁴⁷ *Id.*

using RP as a tool to cut health care costs; instead, it recommended applying RP to broader categories of procedures, realizing that RP can be “a useful step on the path to more reasonable pricing.”¹⁴⁸ If RP is being touted as a cost-saving tool, evidence of small savings casts doubt on its usefulness and viability. But, greater cost savings will be realized as more employers and insurers adopt RP, the number of procedures subject to RP increases, and RP is combined with payment reform strategies.¹⁴⁹

4. Monitoring Potential Cost Shifting

RP’s potential to shift costs should be closely monitored to prevent its negative effects on affordability of care. The fact that RP can be used as a way to shift costs from providers to consumers is a matter of concern.¹⁵⁰ But, this cost shifting can be prevented if consumers are provided sufficient information to understand RP and choose providers within the reference price.¹⁵¹

However, another type of cost shifting is more nuanced and not addressed by RP.¹⁵² In order to understand this cost-shifting phenomenon, let’s look at an example. A health plan has decided to impose a reference price of \$30,000 on hip replacements. An area hospital lowers its price for that procedure from \$40,000 to \$30,000 in order to keep its market share and prevent losing the health plan’s customers. That hospital can make up that difference of \$10,000 by increasing the price of one or more procedures that are not capable of being reference priced, such as emergency cardio thoracic surgery. This cost shifting seems natural for a hospital to do but it also chips away at one of the goals of RP—to lower prices of health care services by reducing the amount paid to providers.

¹⁴⁸ *Id.* at 6–7.

¹⁴⁹ *See infra* Section V.

¹⁵⁰ Letter from Karin Feldman, *supra* note 120; Timothy Jost, *Implementing Health Reform: Third-Party Payments and Reference Pricing*, HEALTH AFF. BLOG (May 22, 2014), <http://healthaffairs.org/blog/2014/05/22/implementing-health-reform-third-party-payments-and-reference-pricing/> (“if employers move to defined-contribution payment for employee benefits and insurers move toward reference pricing, we may reach a point where the combined premium and cost-sharing expenses shifted to employees simply become intolerable”).

¹⁵¹ Price transparency is discussed in the next section.

¹⁵² *From Reference Pricing to Value Pricing*, CATALYST FOR PAYMENT REFORM, http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Reference_Pricing.pdf.

Also, consumers do not stand to benefit in the end when on one hand, they save money by choosing a reference-priced provider for a reference-priced service, while on the other, they are the targets of balanced billing for an emergency, non-reference-priced procedure.

Lastly, there is cost shifting from facility to non-facility charges. In the CalPERS RP experiment, the “\$30,000 payment limit applied only to the hospital’s allowed charges, not to the fees charged by the surgeons and other physicians involved in the patient’s care.”¹⁵³ Facility fees typically account for seventy-five to eighty percent of the total cost of joint replacements.¹⁵⁴ With only the facility fee subject to RP, hospitals have an incentive to shift some of the cost to physician fees, especially since hospitals are buying out physician practices and increasing their non-facility charges.¹⁵⁵

With multiple levels of cost shifting, health plans need to evaluate RP’s effects on affordability of care for consumers because if cost shifting is not controlled, the “balloon effect” of RP will lead to minimal overall savings for the health care system.

5. Price Transparency: Availability and Comprehensibility

One of the important pillars of a RP program is price transparency—making price information available to consumers so they can make informed choices. However, the gaps in price data can hinder both the flow of information necessary for consumers to make educated

¹⁵³ Robinson & Brown, *supra* note 69, at 1393.

¹⁵⁴ Randy Cox, *Reference Pricing--Just Scratching the Surface*, PRICING HEALTHCARE BLOG (Aug. 21, 2014), <http://blog.pricinghealthcare.com/reference-pricing-taken-to-the-next-level/>; *Total Hip Replacement*, HEALTHCARE BLUEBOOK, https://healthcarebluebook.com/page_ProcedureDetails.aspx?id=28&dataset=md&g=Total+Hip+Replacement (last visited Oct. 26, 2014) (total fair price of a hip replacement was listed as \$22,606, out of which facility fees were \$18,671 (82.59% of the total cost), physician fees were \$2,764 (12.22% of the total cost), and anesthesiologist fees were \$1,171 (5.18% of the total cost)); *Total Knee Replacement*, HEALTHCARE BLUEBOOK, https://healthcarebluebook.com/page_ProcedureDetails.aspx?id=31&dataset=MD&g=Total+Knee+Replacement (last visited Oct. 26, 2014) ((total fair price of a knee replacement was listed as \$22,720, out of which facility fees were \$18,671 (82.17% of the total cost), physician fees were \$2,950 (12.98% of the total cost), and anesthesiologist fees were \$1,098 (4.83% of the total cost)).

¹⁵⁵ Cox, *supra* note 154.

decisions and the success of RP programs. Without proper price and quality data, RP programs can push consumers into making tough health care decisions without appropriate information.

Price transparency is “the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.”¹⁵⁶ Price information should ideally include a consumer’s total cost for health care services—any negotiated discounts; all fees for the facility, physician, lab, and other fees; out-of-pocket costs, including co-payments, coinsurance amounts, deductibles; and the gap price.¹⁵⁷ But the problem is that “[e]ven very large plans will lack the historical data to accurately measure the prices they typically pay to smaller hospitals.”¹⁵⁸ Some of the transparency tools used by health plans are limited because of the pressure from the providers with whom they negotiate, the operational challenges they face with respect to the data, and the limitations of existing consumer portals.¹⁵⁹ Therefore, price information might not be that easily accessible to a health plan itself. That further hinders consumers’ access to that information.

Price transparency should accompany information about the quality of care provided at the reference-priced facilities. After equipping consumers with the information they need, it is important that the information readily available at the time of purchasing and is presented in an understandable way. Helping consumers realize that high prices do not necessarily mean better quality and that some of the lower-priced hospitals often have high quality scores¹⁶⁰ requires displaying price and quality data

¹⁵⁶ *Price Transparency*, CATALYST FOR PAYMENT REFORM, <http://www.leapfroggroup.org/media/file/PriceTransparencyActionBrief.pdf> (last visited Oct. 26, 2014).

¹⁵⁷ *Id.* For example: “An insurer has negotiated a rate of \$1,000 with a particular in-network provider for a chest MRI, and therefore, the cost is \$1,000. A consumer has \$200 remaining to meet his/her deductible and the coinsurance is \$160; the individual is responsible for \$360 and the insurer pays \$640. In this case the consumer’s “price” for the MRI is \$360. Price transparency exists when, for example, prior to seeking care, a consumer knows his price will be \$360 for that particular provider and can compare the price for chest MRIs with other providers. It is also important for consumers to understand the total payment for the service, including what the plan (or purchaser) pays and the remaining price they owe for that service”).

¹⁵⁸ White & Eguchi, *supra* note 140, at 6.

¹⁵⁹ CATALYST FOR PAYMENT REFORM, *supra* note 152, at 4.

¹⁶⁰ Bobbi Coluni, *Save \$36 Billion in U.S. Healthcare Spending Through Price Transparency*, THOMSON REUTERS, 4 (2012),

side-by-side. Also, providing independent information about quality will allow consumers to consider the cost of care of services and not rely solely on their physician's advice.¹⁶¹ Creating an infrastructure that can obtain and support such information will require a significant investment, which might be a deterrent for employers planning to adopt RP programs.

In addition to initial consumer education about a RP program, continued support should be available for consumers to understand this new layer of complexity. Differentiating between in-network, out-of-network, referenced-priced-in-network providers, and non-reference-price-in-network providers will be a difficult task, even if applied to non-urgent procedures. Some form of assistance should be available to consumers to choose from and between reference-priced providers that best suit their health and financial concerns. Those who adopt RP must keep these long-term considerations in mind to ensure RP's continued success, prevention of any adverse effects on consumers, and widespread adoption by health plans.

V. VARIATIONS OF RP

As the health care industry works to develop standards to evaluate the current RP programs, it is important to keep in mind how RP programs can work with the emerging health delivery and payment models. Some variations improve the current RP programs, while others are designed to lift RP from a mere cost-saving tool to an important component of the payment delivery system.

Unlike CalPERS, Kroger Co.'s RP program included both the facility fees and professional charges.¹⁶² This prevented any cost shifting between the different fees and allowed consumers to see the total cost of a reference-priced procedure. This method, however, does not prevent providers from shifting costs to other post-procedure services, and it falls short of taking RP out of its role as a benefit-design mechanism and placing it alongside the payment reform tools. But it is important to note that cost-

http://www.hreonline.com/pdfs/06022012Extra_ThomsonReutersStudy.pdf; Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Health Care — Challenges and Potential Effects*, NEW ENG. J. MED. 891, 892 (2011) (“The belief that higher-cost care must be better is so strongly held that higher price tags have been shown to improve patients’ responses to treatments through the placebo effect”).

¹⁶¹ Sinaiko & Rosenthal, *supra* note 160, at 892.

¹⁶² Letter from Theresa Monti, *supra* note 91, at 3.

shifting between different fees can be reduced if most of the costs and fees associated with a procedure can be included in the reference price. Similarly, RP can be applied to a single or multiple CPT¹⁶³ codes, thereby allowing the health plan to inform consumers of their finite costs. However, with complex procedures involving multiple CPT codes, a patient can be left with a large bill even if he or she chooses a reference-priced provider. Francois de Brantes et al. points out:

For example, a physician might decide to perform multiple diagnostic imaging tests prior to and after the procedure, or to select different types of imaging tests than some of their peers. Similarly, after the procedure, the orthopedist might recommend a stay at a rehabilitation facility, while another might recommend a few sessions of physical therapy. Finally, the price might vary depending on the setting in which the plan member receives the service. As such, the price, mix, and frequency of services in a joint replacement procedure can vary, even when adjusting for the severity of the patient.¹⁶⁴

This problem can be solved if RP is coupled with payment reform mechanisms, such as bundled payments. A bundled payment “is a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment.”¹⁶⁵ It shifts the risk to the providers for the cost of services for a particular treatment or condition and any resulting preventable complications.¹⁶⁶ Providers are protected in case of serious complications in which they have to incur unexpected costs. Since it is a single payment to the provider, it lends itself

¹⁶³ CPT stands for current procedural terminology. “The CPT-4 codes are used to describe medical procedures and physicians services, and is maintained and distributed by the American Medical Association.” *Code Sets*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 26, 2014, 4:01 PM.), <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/CodeSets.html>.

¹⁶⁴ Francois de Brantes et al., *supra* note 4, at 3.

¹⁶⁵ Suzanne Delbanco, *The Payment Reform Landscape: Bundled Payment*, HEALTH AFF. BLOG (July 2, 2014), <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>.

¹⁶⁶ *Id.*; see also *Analysis of Bundled Payment*, RAND CORP., http://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html (last visited Oct. 26, 2014).

to be a natural partner of RP. According to Catalyst for Payment Reform, “[c]oupling a reference pricing strategy with a bundled payment to providers for the entire episode of care could make pricing easier and create alignment among consumers, employers, and providers in a number of ways.”¹⁶⁷ As with the current RP program, a consumer will select a provider that offers a reference-priced bundle and the consumer will only incur out-of-pocket costs if he chooses a provider with a higher priced bundle.¹⁶⁸

This combination of RP and bundled payments can result in “alignment” between the provider, the insurer, and the insured.¹⁶⁹ It will also allow for cost predictability for both the insurer and the consumer.¹⁷⁰ Another benefit will be greater provider accountability for defined outcomes and financial liability for the provider for costs above the bundled reference price.¹⁷¹ Additionally, by including a stop loss cap at the 95th percentile of costs, the employee and the provider can be protected from catastrophic out-of-pocket expenses resulting from factors outside of their control.¹⁷² Due to the administrative complexities,¹⁷³ legal hurdles,¹⁷⁴ and required technological capabilities,¹⁷⁵ bundled payments have not been widely accepted, despite their cost-saving potential.

In addition to bundled payments, Catalyst for Payment Reform predicts that RP will be incorporated with other payment reform methods, including centers for excellence contracting¹⁷⁶ and global payments.¹⁷⁷ RP

¹⁶⁷ Francois de Brantes et al., *supra* note 4, at 1.

¹⁶⁸ *Id.* at 4.

¹⁶⁹ *Id.* at 6.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 7.

¹⁷² Francois de Brantes et al., *supra* note 4, at 7.

¹⁷³ Brook et al., RAND CORP., *supra* note 20.

¹⁷⁴ *Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context*, ROBERT WOOD JOHNSON FOUND.,

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407662 (“the legal framework for compliance has not become more flexible for bundled payments in the commercial payor context”).

¹⁷⁵ *Information Technology for Bundled Payment*, THE MITRE CORP. (Dec. 16, 2011), http://www.ahcancal.org/facility_operations/hit/Documents/IT_Bundled_Payment.pdf.

¹⁷⁶ Robinson & MacPherson, *supra* note 111, at 2029. (“Centers-of-excellence contracting channels patients to hospitals that provide high-quality care and are willing to discount their prices in exchange for the higher volume of patients”).

has the potential to become a valuable cost-saving tool, but its limitations need to be recognized and monitored closely. The Department should start by taking a closer look at the current RP programs to assess whether RP is a strategy that is compatible with the goals of the evolving health care system.

VI. CONCLUSION

RP is an effective benefit-design model that is helping to bend the health care cost curve. Andrea Caballero, Program Director at the Catalyst for Payment Reform, perfectly stated that even though RP is a “short-term fix,” it is “one of the few short-term fixes that is actually seeing positive results.”¹⁷⁸ With its success in both the international pharmaceutical market and the U.S. market for medical procedures and services, it has proven its potential as a cost-saving device. But, it has its limitations, in terms of scope and application, that must be recognized so that regulators overseeing its implementation can effectively track its progress, monitor its effect on access, cost, and quality of care, and allow its incorporation into new payment reform mechanisms. While the health care system should be wary of new strategies which can potentially impact consumers’ access to affordable, high-quality care, bending the cost curve will require disruptive innovations that can transform the power dynamics in the health care marketplace.

¹⁷⁷ “Global payment models vary based on the amount of risk assumed by the provider organization and the methods used to limit risks. Risks can be limited based on what services are included in the global payment and what, if any, adjustments are considered when evaluating provider performance.” Ann Robinow, *The Potential of Global Payment: Insights from the Field*, THE COMMONWEALTH FUND (Dec. 2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1373_Robinow_potential_global_payment.pdf.

¹⁷⁸ Monday, November 18, 2013: Reference Pricing: Will Price Caps Help Contain Healthcare Costs?, YOUTUBE, https://www.youtube.com/watch?v=VJmlo_A678 (last visited Dec. 14, 2014).

AN ALTERNATE THEORY OF *BURWELL V. HOBBY LOBBY*

JESSICA L. ROBERTS¹

If asked what was the central issue in Burwell v. Hobby Lobby, most informed Americans would likely reply that it was the conflict of reproductive health and religious freedom. This Essay, however, argues for an alternate reading of that now infamous case. It proposes that Hobby Lobby is best understood as a demonstration of how the continued reliance on employer-provided benefits renders employers de facto health-care policy makers with the ability to profoundly impact the health-care access of millions of Americans.

INTRODUCTION

In 2014, the Supreme Court decided the controversial case *Burwell v. Hobby Lobby*, holding that, pursuant to the Religious Freedom Restoration Act, private employers could lawfully refuse to comply with the Affordable Care Act's (ACA) contraceptive mandate.² Common rallying cries among opponents of Hobby Lobby's position were "No Bosses in My Bedroom" and "Birth Control is Not My Boss's Business."³

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² 573 U.S. ____ (2014).

³ Several protestors held signs with type of slogans. See, e.g., <http://www.jta.org/wp-content/uploads/2014/04/hobby-lobby.jpg>; <http://thinkprogress.org/wp-content/uploads/2014/03/GW-college-dems-hobby-lobby-scotus.jpg>. For more about activism invoking this theme, see NARAL, Not My Bosses Business, available at <https://secure.prochoiceamerica.org/site/Advocacy?cmd=display&page=UserAction&id=6005>; UltraViolet, No Bosses in My Bedroom, available at

Although the legal issue presented in the case was whether a private corporation is exempt from a law that its owners oppose for religious reasons, many Americans' core objection to the decision was its implication that private employers could dictate our access to reproductive health care.

This Essay offers an alternate theory of *Hobby Lobby*. I propose that instead of a case about religious freedom, *Hobby Lobby* is best understood as a case about the potential perils of the employer-provided benefits system. While other scholars have noted the effect of employment on health insurance and, consequently, health-care access, *Hobby Lobby* reveals that employers dictate even more about the ability to access health care in the United States than simply whether an individual has insurance.

In the past, private employers have offered their employees relatively generous coverage of their own volition. However, following the passage of the Affordable Care Act (ACA) some employers will find themselves facing legal penalties if they do not provide comprehensive, affordable health insurance to their full-time employees. As primary providers of health insurance, private employers regularly make any number of employment- and insurance-related decisions that ultimately shape the contours of health-care access: whom to insure, what policies to offer, which treatments and providers to cover, and more. Consequently, employers are vested with decisions that directly impact the type and amount of health care that is available to millions of Americans.

In reframing the *Hobby Lobby* decision, this Essay exposes an unfortunate reality: Private employers are acting as de facto health-care policy makers. Following the Supreme Court's controversial decision in *Hobby Lobby*, Americans have gotten a glimpse of how an individual employer's decisions can affect the health-care access of its employees. However, this Essay reveals that these restrictions go well beyond the issue of contraception. As employer-provided benefits remain an enduring aspect of the American health-insurance system, at least in the short-term,⁴ it is essential to explore their effect on accessing needed health care.

This Essay proceeds in three parts. Part I outlines the dominant narrative of *Hobby Lobby* as a religious freedom case and the continued reliance on employers to provide health insurance in the United States. Part II explores how employers—many of whom have even stronger incentives to provide health insurance to their employees post-ACA—act

http://act.weareultraviolet.org/sign/scotus_birthctrl_video/#

⁴ See Jessica L. Roberts, *The ACA Double-Bind* (in progress) (on file with author).

as both gatekeepers and regulators of health care. Part III then reframes the issue as a classic agency problem and proposes that the solution might not be further regulation but a move away from the employer-provided system.

I. DOMINANT NARRATIVE OF *BURWELL V. HOBBY LOBBY*

Part I describes the *Hobby Lobby* case and its political and popular framing as a titanic conflict between socially conservative religious rights advocates and socially liberal champions of reproductive health. However, this reading of the case fails to address the issue of why a private company like Hobby Lobby is offering health insurance to its employees. To address this inquiry, Part I then turns to the employer-provided benefits system that made the controversy in *Hobby Lobby* possible and how ACA recently changed that system.

A. THE SUPREME COURT CASE

Given the wide spread media attention it received, many Americans may already be familiar with. Nonetheless, I begin by briefly summarizing the case and the statutory provisions it interprets.

Among the statute's many provisions, the Affordable Care Act (ACA) requires group health-insurance policies—including employer-provided plans—to offer women “preventative care and screenings” without “any cost sharing requirements” absent an applicable exception.⁵ While Congress did not specifically define what constituted “preventative care and screenings,” it authorized the Health Resources and Services Administration (HRSA), a division of the Department of Health and Human Services (HHS), to issue guidance. In response to this charge, HRSA drafted the Women's Preventative Service Guidelines, which states that non-exempt employers must cover “[a]ll Food and Drug Administration [(FDA)] approved contraceptive methods, sterilization procedures, and patient education and counseling” with no cost sharing.⁶ These regulations became known as the contraceptive mandate. HRSA also created certain exemptions for religious non-profit organizations and grandfathered plans.⁷

⁵ 42 U.S.C. § 300u-11 (2010).

⁶ Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventative Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (Feb. 15, 2012).

⁷ *Hobby Lobby Stores, Inc.*, No. 13-354, slip op. at 5 (U.S. Jun. 30, 2014).

In *Burwell v. Hobby Lobby*, three closely held organizations challenged their obligations under the contraceptive mandate as violating their sincerely held religious beliefs pursuant to the Religious Freedom Restoration Act (RFRA). RFRA forbids the Federal Government from taking actions that substantially burden religious exercise unless that action is the least restrictive means to serve a compelling government interest. Justice Alito drafted the majority opinion. First, the Court held that RFRA's definition of a person includes corporations and that corporate entities are capable of religious exercise.⁸ Addressing whether for-profit corporations could hold sincere religious beliefs, the Court stated that "[t]he companies in the cases before us are closely held corporations, each owned and controlled by members of a single family, and no one has disputed the sincerity of their religious beliefs."⁹ Turning to the substantial burden inquiry, the Court noted that failing to offer contraception would result in tax penalties of one hundred dollars per day for each affected individual.¹⁰ It also acknowledged that the companies could drop coverage altogether but that they would be subject to the no-offer penalty,¹¹ described in the following Sub-Part.¹² (Amici suggested that stopping coverage and paying the penalty might actually be a cost-efficient decision for employers, a possibility alluded to in Part II of this Essay.¹³) After finding that the contraceptive mandate posed a substantial burden on religious exercise, the Court then turned to the compelling interest and least restrictive means analysis.¹⁴ Assuming—but not holding—that the Government has compelling interests in public health and gender equality, the Court asserted that HHS failed to demonstrate that it could not achieve its objectives through means that would not substantially burden the exercise of religion, especially given the accommodations already built into the regulations.¹⁵ In sum, the Court's 5-4 majority opinion held that the ACA's contraceptive mandate, as applied to closely held corporations with religious objections, violated RFRA.¹⁶

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 7-8.

¹¹ *Id.* at 8.

¹² *Infra* notes 51-53.

¹³ *Infra* note 85.

¹⁴ *Burwell v. Hobby Lobby Stores, Inc.*, No. 13-354, slip op. at 2 (U.S. Jun. 30, 2014).

¹⁵ *Id.* at 2-3.

¹⁶ *Id.* at 3.

Several other justices filed their own opinions in the case. Justice Kennedy's concurrence, responding to Justice Ginsburg's dissent, first stated that both sides agree that the purpose of RFRA is to protect religious freedom.¹⁷ In discussing the Court's application of the substantial burden test, he emphasized that the majority premised its analysis on the assumption that the contraceptive mandate furthers a legitimate and compelling government interest.¹⁸ Justice Kennedy explained that a direct mandate to provide coverage for contraception is not the least restrictive way to achieve those interests because an accommodation is available for religious objections that would allow access to contraception without infringing on religious beliefs.¹⁹

In Justice Ginsburg's fiery dissent, she framed the issue as a matter of women's rights, asserting that the Court held "RFRA demands accommodation of a for-profit corporation's religious beliefs no matter the impact that accommodation may have on third parties who do not share the corporation owners' religious beliefs—in these cases thousands of women employed by Hobby Lobby and Conestoga or dependents of persons those corporations employ."²⁰ She first described the constitutional right to reproductive freedom, the existing cost disparities for women's preventive health care, and the ACA's and its accompanying regulations' requirement that insurers cover women's preventive health services with no cost sharing.²¹ Justice Ginsburg then went on to critique the Court's extension of RFRA's protections to for-profit corporations.²² Even if for-profit corporations meet the definition of "person" for RFRA purposes, she maintained that those entities must still demonstrate that following the contraceptive mandate "substantially burdens" the business's exercise of religion,²³ noting that the substantiality of a burden is a separate inquiry from the sincerity of a belief.²⁴ She concluded that "the connection between the families' religious objections and the contraceptive coverage requirement is too attenuated to rank as substantial."²⁵ However, even assuming a substantial burden, Justice Ginsburg believed the Government had compelling interests in both public health and the well-being of

¹⁷ *Id.* at 1 (Kennedy, J., concurring).

¹⁸ *Id.* at 2.

¹⁹ *Id.* at 3.

²⁰ *Id.* at 2 (Ginsburg, J., dissenting).

²¹ *Id.*

²² *Id.*

²³ *Id.* at 10-11.

²⁴ *Id.* at 11.

²⁵ *Id.* at 22.

women.²⁶ With regard to RFRA's least restrictive means test, she opined that no less restrictive yet equally effective policy would simultaneously satisfy the plaintiff's religious objections and accomplish the contraceptive mandate's goal of ensuring that women receive costless preventative care.²⁷ She elaborated that "[i]mpeding women's receipt of benefits 'by requiring them to take steps to learn about, and to sign up for, a new [government-funded and administered] health benefit' was scarcely what Congress contemplated."²⁸ Justice Ginsberg ended her dissent by asserting that when entities with religious beliefs enter commerce they accept that their beliefs will not be imposed on others engaging in that commercial activity.²⁹ She would, therefore, have limited RFRA's religious exemptions to organizations with a religious purpose, primarily engaged in conduct to further that purpose.³⁰

Finally, Justices Breyer and Kagan wrote a mercifully short dissent explaining that, while they agreed with Justice Ginsburg's assessment that the plaintiffs should have failed on the merits, they did not believe that it was necessary to reach the issue whether for-profit corporations or their owners can bring RFRA claims.³¹

Politicians and the media depicted *Hobby Lobby* as an epic clash between two cherished American constitutional rights (and their passionate advocates). The case might as well have been called *Reproductive Choice v. Religious Freedom*. Prior to the decision, Senator Elizabeth Warren commented: "I cannot believe that we live in a world where we would even consider letting some big corporation deny the women who work for it access to the basic medical tests, treatments or prescriptions that they need based on vague moral objections."³² Republican Senators had their own view, explaining in their amicus brief, "[t]his case does not implicate the individual right to access to contraceptives, which this Court's cases have long protected. Instead, it concerns whether the federal government can force employers to violate their good-faith religious belief and pay for the contraceptives of others."³³ The central issue was thus framed in terms of reproductive health and religious freedom.

²⁶ *Id.* at 23-24.

²⁷ *Id.*

²⁸ *Id.* at 28.

²⁹ *Id.* at 31-35.

³⁰ *Id.* at 35.

³¹ *Id.* at 1. (Breyer, J. and Kagan, J., dissenting).

³² Elizabeth Warren, *We Don't Run this Country for Corporations* (Mar. 26, 2014), <http://elizabethwarren.com/blog/we-dont-run-this-country-for-corporations>.

³³ Brief for Senator Ted Cruz et al. as Amici Curiae Supporting Respondent at

After the decision, politicians continued to weigh in on the side of either women's health care or religious rights. House Speaker John Boehner issued this statement:

Today's decision is a victory for religious freedom and another defeat for an administration that has repeatedly crossed constitutional lines in pursuit of its Big Government objectives. The mandate overturned today would have required for-profit companies to choose between violating their constitutionally-protected faith or paying crippling fines, which would have forced them to lay off employees or close their doors.³⁴

On the other side of the debate, Minority Leader Representative Nancy Pelosi weighed in:

Today, the Supreme Court took an outrageous step against the rights of America's women, setting a dangerous precedent that could permit for-profit corporations to pick and choose which laws to obey. This deeply misguided and destructive decision is a serious blow to Americans' ability to make their own health decisions.³⁵

The media echoed this framing. One article described the case as a "victory at the court [sic] for the religious right."³⁶ Another, discussing the aftermath of the case, queried what would be the "next fronts in the contraception fight."³⁷

In his insightful article, *Regulating Employment-Based Anything*, Brendan S. Maher interrogates the popular construction of the *Hobby*

3, *Burwell v. Hobby Lobby Stores, Inc.*, No. 13-354, slip op. 6 (2015).

³⁴ *Speaker Boehner on the Supreme Court's HHS Mandate Ruling* (June 30, 2014) <http://www.speaker.gov/press-release/speaker-boehner-supreme-court-s-hhs-mandate-ruling#sthash.b56Pq4wH.dpuf>.

³⁵ Press Release, *Pelosi Statement on Supreme Court Hobby Lobby Decision*, (June 30, 2014), <http://pelosi.house.gov/news/press-releases/pelosi-statement-on-supreme-court-hobby-lobby-decision>.

³⁶ Richard Wolf, *Justices Rule for Hobby Lobby on Contraception Mandate*, USA TODAY, Jun. 30, 2014, <http://www.usatoday.com/story/news/politics/2014/06/30/supreme-court-hobby-lobby-religion-contraception-obama/11473189/>.

³⁷ Jaime Fuller, *After Hobby Lobby: The Next Fronts in the Contraception Fight*, WASH. POST, Jul. 1, 2014, <https://www.washingtonpost.com/news/the-fix/wp/2014/07/01/after-hobby-lobby-the-next-fronts-in-the-contraception-fight/>.

Lobby case.³⁸ He notes that many commentators stated the issue in the case was whether private employers should “pay” for their employees’ contraception.³⁹ Maher proposes that this framing misses key nuances of the employer-provided system.⁴⁰ Mainly, as he explains, “[e]mployers are not paying for contraception in the sense that many of the accounts assumed; they are administering a plan that passes employee money along to an insurer who provides coverage that includes contraception.”⁴¹ Maher asserts that to be compelled to be an administrator is a very different obligation than being compelled to spend money that would otherwise belong to the employer.⁴²

But regardless of one’s beliefs regarding contraceptive access or religion, these conflicts and commentaries raise a bigger question: Why are employers making decisions about health-insurance coverage in the first place?

B. EMPLOYER-PROVIDED BENEFITS & THE AFFORDABLE CARE ACT

The central conflict in *Hobby Lobby* would not have occurred absent the American reliance on employer-provided benefits. Of primary interest to this Essay is the crucial role employers occupy by providing private health insurance to millions of individuals in the United States.⁴³ Despite the varied ways of obtaining coverage, a majority of non-elderly Americans are insured through their employers.⁴⁴ When the ACA passed,

³⁸ Brendan Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257 (2016).

³⁹ *Id.* Cf. James D. Nelson, *Conscience, Incorporated*, 2013 MICH. ST. L. REV. 1565 (framing *Hobby Lobby* in terms of which organizations should be able to assert rights of conscience).

⁴⁰ Maher, *supra* note 38.

⁴¹ *Id.*

⁴² *Id.*

⁴³ The U.S. is the only country that relies heavily on employers to provide health insurance. Jacob S. Hacker, *Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform*, 34 BRIT. J. POL. SCI. 693, 697 (2004).

⁴⁴ *Key Facts About the Uninsured Population*, KAISER FAMILY FOUND. (Oct. 5, 2015), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>; Melissa Majerol et al., *The Uninsured: A Primer – Key Facts About Health Insurance and the Uninsured in America* [hereinafter *The Uninsured: A Primer*], KAISER FAMILY FOUND. (Jan. 13, 2015); Diane Rowland & Adele Shartzter, *America’s Uninsured: The Statistics and Back Story*, 36 J. L. MED. &

one-hundred fifty-seven million Americans had employer-provided health insurance.⁴⁵ At the time, approximately fifty-six percent of individuals under the age of sixty-five hold such policies,⁴⁶ which made employers the primary source of health insurance for individuals who are not covered by Medicare.⁴⁷ The proportion of individuals insured through their employers has led one author to refer to employer-provided benefits as “the primary source of Americans’ health insurance for most of the past century”⁴⁸ and others to call employer-provided coverage “the bedrock of the health insurance system.”⁴⁹ Thus, employers are a primary source of health insurance in the United States.

While employers voluntarily began offering health insurance to their employees as the result of World War II wage controls and favorable tax status,⁵⁰ the ACA further entrenched our dependence on employer-provided benefits. Among the ACA’s most controversial provisions was the law’s so-called “employer mandate.” That provision requires large employers—defined in the law those that employ more than fifty workers—to offer affordable coverage of minimum value to ninety-five percent of their “full-time” employees, employees who work thirty or more hours per week.⁵¹ Lower-wage workers—individuals whose income is

ETHICS 618, (2008).

⁴⁵ Mark Merlis, *The Affordable Care Act and Employer-Sponsored Insurance for Working Americans*, ACAD. HEALTH 1 (2011), http://www.academyhealth.org/files/nhpc/2011/AH_2011AffordableCareReportFINAL3.pdf.

⁴⁶ The Uninsured: A Primer, *supra* note 44. Medicare covers almost all Americans over age sixty-five.

⁴⁷ Rowland & Shartzer, *supra* note 44, at 621.

⁴⁸ Christine Eibner, *Employer-Provided Health Insurance: Why Does It Persist, and Will It Continue after 2014?*, NEW ENG. J. MED. SUPP. (2003), available at <http://images.nejm.org/editorial/supplementary/2013/hbr18-eibner.pdf>.

⁴⁹ See Rowland & Shartzer, *supra* note 44, at 619. Employer-provided benefits have also been referred to as the “cornerstone” of the American health-care system. See John Bronsteen et al., *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2298-99 (2008).

⁵⁰ Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 888 (2011) [hereinafter *Employment-Based*]. Unions and the return of the military were also arguably contributing factors. For a thorough discussion of the history of the development of the employer-provided benefits system, see *id.* at 886-92.

⁵¹ ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); see also *The Uninsured: A Primer*, *supra* note 44. However, not all scholars agree the mandate truly operates as such. See, e.g., Kathryn Moore, *The Pay or Play Penalty Under the Affordable Care Act*:

lower than four-hundred percent of the federal poverty level—may qualify for a refundable tax credit to purchase insurance for themselves and their dependents.⁵² If an employer fails to offer a health plan and just one of its employees purchases subsidized coverage on an exchange, the employer will face a tax of up to two-thousand dollars for *each full-time employee*, not counting the first thirty employees.⁵³ Likewise, if an employer offers a health plan but the plan is not affordable—either the required contribution exceeds 9.5 percent of an employee’s income or the plan pays for less than sixty percent of the covered services—and a qualifying employee obtains tax-subsidized coverage on an exchange, then the employer must pay a three thousand dollar penalty for *each subsidized employee who purchases coverage*.⁵⁴ Thus, the “pay-or-play penalty” actually encompasses two related tax penalties: the “no offer penalty” and the “unaffordable coverage penalty.”⁵⁵

However, the employer mandate is not the only way in which the ACA creates incentives for employers to provide health insurance. Because of the limitations of the small-group system, small employers have historically been far less likely to offer insurance to their employees.⁵⁶ Hence, a substantial portion of the uninsured who are part of working families work (or have a family member who works) for a small employer.⁵⁷ Although the mandate does not apply to small employers, the

Emerging Issues (in progress) [hereinafter *Pay or Play*].

⁵² ACA, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213-20 (codified as amended at 26 U.S.C. § 36B); Merlis, *supra* note 45, at 45.

⁵³ ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); Merlis, *supra* note 45, at 2; *see also* The Uninsured: A Primer, *supra* note 44. Some employers have thus assumed that eighty employees is the true threshold for compliance as there will not be a financial impact for employees fifty to seventy-nine. James N. Nelson, *The Patient Protection and Affordable Care Act, ERISA § 510 and the Next Generation of Benefits Litigation Concerns*, ABA Employee Benefits Committee Newsletter.

⁵⁴ ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); Merlis, *supra* note 45, at 2.

⁵⁵ I have borrowed the terms “pay-or-play penalty,” “no offer penalty,” and “unaffordable coverage penalty” from Kathy Moore. *See generally* Moore, *Pay or Play*, *supra* note 51. Moore includes a very useful diagram in her Essay, mapping how the pay-or-play penalty operates. *Id.*

⁵⁶ Amy B. Monahan & Daniel Schwarcz, *Saving Small Employer Health Insurance*, 98 IOWA L. REV. 1935, 1942-44 (2013) [hereinafter *Saving*].

⁵⁷ The mandate applies only to employers with fifty or more full-time employees. ACA § 1513, I.R.C. § 4980(H). By failing to cover smaller employers, the mandate could leave a number of individuals uninsured. *See* The

law addresses this issue via tax credits designed to help smaller entities—employers with less than twenty-five employees and annual wages under fifty thousand dollars—cover the costs of providing health insurance to their workers.⁵⁸ These credits became available the year the law passed;⁵⁹ however, no credits are available after the start of this year.⁶⁰ Given the modest nature of the credits and the short lifespan of the program, there is speculation that this incentive will do little to encourage small employers to offer coverage when they haven't in the past.⁶¹ Yet regardless of their impact they provide another example of how the ACA not only perpetuates but attempts to strengthen the American reliance on employer-provided benefits.

In sum, while a vast majority of employers were already offering health insurance to their employees prior to health-care reform,⁶² the ACA further codified our dependence on employers as health-insurance providers through the employer mandate and other provisions designed to encourage employers to provide insurance. Without the employer-provided benefits system there would be no *Burwell v. Hobby Lobby*. As a result, this Essay advocates understanding *Hobby Lobby* as primarily a case about the continued reliance on employers to provide health insurance and the shortcomings of the employer-provided system.

* * *

Commentators framed *Burwell v. Hobby Lobby* as the religious right and the socially liberal left locking horns on the issue of women's

Uninsured: A Primer, *supra* note 44 (explaining that “the employer requirements may help many uninsured individuals with a worker in their family, a majority of uninsured workers work in small firms that are not required to provide insurance coverage”).

⁵⁸ ACA, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237-42 (codified as amended at 26 U.S.C. § 45R); I.R.C. § 45R(d); Merlis, *supra* note 45, at 3; The Uninsured: A Primer, *supra* note 44; *see also* Moore, *Employment-Based*, *supra* note 50, 912-17 (describing the tax credit and assessing its probable effect).

⁵⁹ ACA, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237-42 (codified as amended at 26 U.S.C. § 45R); The Uninsured: A Primer, *supra* note 44.

⁶⁰ ACA, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237-42 (codified as amended at 26 U.S.C. § 45R); Merlis, *supra* note 45, at 3.

⁶¹ Merlis, *supra* note 45, at 3.

⁶² Rowland & Shartzler, *supra* note 44, at 621; *see also* Merlis, *supra* note 45, at 3 (“In 2010, 95 percent of firms with 50 to 199 workers and 99 percent of firms with 200 or more workers offered coverage to at least some of their employees.”).

reproductive health. Yet this construction only tells part of the story. If read as an employer-provided benefits case, *Hobby Lobby* is about much more than just access to contraception. Employers make numerous choices that impact how a substantial number of Americans access health care. Hence, Part II argues that the employer-provided system renders employers de facto health-care policy makers.

II. EMPLOYERS AS HEALTH-CARE POLICY MAKERS

Employers make all kinds of decisions that impact how a substantial number of Americans access health care. In other words, they are making health-care policy. Employers act as health-care policy makers in two related ways: as gatekeepers and as regulators. As gatekeepers, employers affect *whether* people have access to health care. Their decisions to offer benefits or to dump potentially costly employees may determine whether certain people can access the health-care system at all. As regulators, employers affect *how* people access health care. The structure of their plans, the kind of coverage they offer, and whether they include cost-sharing mechanisms can all impact how an individual obtains health care.

A. EMPLOYERS AS GATEKEEPERS

Health care in the United States is expensive. America spends approximately eight thousand dollars per person each year on health care⁶³ and that number continues to rise.⁶⁴ This amount is more than two and a half times as much as other developed countries.⁶⁵ Because rising costs render health care unaffordable, many people in the United States must depend on health insurance to finance their medical treatment. Thus, having insurance may in many circumstances be a prerequisite for

⁶³ Jason Kane, *Health Costs: How the U.S. Compares with Other Countries*, PBS Newshour, Oct. 22, 2012, available at <http://www.pbs.org/newshour/rundown/health-costs-how-the-us-compares-with-other-countries/> (stating that the United States pays \$8,233 per person each year); *see also id.* (explaining that the next highest spenders all spent at least \$3,000 and the average annual spending for developed countries was \$3,268 per person (quoting Mark Pearson)).

⁶⁴ Annie Lowery, *Health Care Spending's Recent Surge Stirs Unease*, N.Y. TIMES, April 19, 2014.

⁶⁵ *Id.*; Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, N.Y. TIMES, June 1, 2013.

accessing needed health care. To be sure, *having* health insurance does not alone promise access to good health care, but *lacking* insurance certainly impedes it.⁶⁶ In short, being uninsured affects whether, when, and where individuals access the health-care system.⁶⁷ Employers act as gatekeepers to health care in their decisions to offer benefits and to engage in employee dumping.

1. Whether to Offer Benefits

While employer-provided benefits are a crucial component of the American health insurance system, not all workers receive health insurance from their employers. Some employees, such as part-time workers, may not be offered health insurance, and, even of the ones that are, not all can afford to pay their portion of the premiums.⁶⁸ While some uninsured workers may be employed part-time or as independent contractors, the majority are either self-employed or work for small employers who do not offer benefits.⁶⁹ Employers in certain industries are less likely to offer their employees coverage.⁷⁰ Significantly, over eighty percent of uninsured workers have blue-collar jobs.⁷¹ Hence, not all workers have historically been eligible for coverage and even if they qualify, the policies themselves may be prohibitively expensive. Perhaps surprisingly given the reliance on employers to provide health insurance, three-quarters of the uninsured are actually part of working families.⁷² Employers, therefore, have rarely insured all of their employees. On average, they have covered seventy-

⁶⁶ Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 25 (2010)..

⁶⁷ Rowland & Shartzter, *supra* note 44, at 618.

⁶⁸ *Id.* at 621; *see also* Key Facts, *supra* note 44; The Uninsured: A Primer, *supra* note 44.

⁶⁹ Key Facts, *supra* note 44.

⁷⁰ *Id.* Individuals who work in manufacturing, professional services, and the public sector are more likely to receive employer-provided benefits. *Id.*

⁷¹ *Id.*

⁷² The Uninsured: A Primer, *supra* note 44. Approximately 60% of the uninsured have at least one full-time worker in the family and 16% have at least one part-time worker. *Id.*; Key Facts, *supra* note 44; *see also* The Uninsured: A Primer, *supra* note 44 (reporting the numbers as 66.7% and 20.2%, respectively); Rowland & Shartzter, *supra* note 44, at 620 (reporting the numbers at 70% and 11%, respectively).

seven percent of their workers.⁷³ Yet when employers do offer health insurance, their employees are highly likely to take them up on it.⁷⁴

Several employer-provided plans have historically excluded some of their full-time employees, usually those individuals who make less money.⁷⁵ As a group, low-income workers are less likely to be covered through their employers than their high-income counterparts.⁷⁶ Of course, the ACA will change the way in which employers can limit the coverage they provide to some extent. As mentioned, the employer mandate requires large employers to provide insurance to all of their full-time employees or face a penalty.

Recently, employers have had a potentially restrictive effect on health-care access by reducing the benefits available to individuals who are not the employee. In particular, employers have begun cutting coverage for working spouses who have access to health insurance through their own jobs, following the passing of the ACA.⁷⁷ These cuts have taken different forms. Whereas some employers have added a surcharge or increased the employee's share of the premium for spousal coverage, others have simply eliminated it.⁷⁸ Employers have reduced coverage for working spouses for explicitly cost-related reasons.⁷⁹ For example, UPS maintained it would save a whopping sixty million dollars per year by cutting benefits for spouses who are eligible for health insurance through their own employers.⁸⁰

Even after the ACA, employers will not necessarily uniformly offer coverage to their employees. Recall that the mandate does not apply to smaller employers and the tax credits designed to facilitate their entrance into the market ended in 2015. Consequently, employers of fewer than fifty that have not previously offered health insurance to their employees have little added incentive to start now. Indeed, they could arguably have less incentive, given that employees can now purchase often heavily subsidized policies on the exchanges. Additionally, larger employers could still decide not to offer their employees coverage and nominally comply with the law. One way that employers could avoid the requirements of the

⁷³ The Uninsured: A Primer, *supra* note 44.

⁷⁴ *Id.*

⁷⁵ Merlis, *supra* note 45, at 4.

⁷⁶ Moore, *Employment-Based*, *supra* note 50, at 896.

⁷⁷ Moore, *Pay or Play*, *supra* note 51.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.* (citing Jay Hancock, *UPS Won't Insure Spouses of Many Employees*, USA TODAY (Aug. 20, 2013)).

ACA would be to keep their number of full-time employees below the employer mandate's fifty full-time workers threshold. Employers right at the cusp of the mandate could opt not to hire new workers⁸¹ or to hire new workers exclusively on a part-time or contract basis.⁸² Employers whose workforce already exceeds fifty employees could either fire enough employees to put them below the cut-off⁸³ or could switch certain employees to part-time or contract work.⁸⁴ Alternatively, employers might opt to drop coverage altogether and instead pay the relatively modest tax penalties.⁸⁵

How an employer's decision about offering benefits will affect the health-care access of its employees depends on the individual employee's income and the scope of the coverage the employer would have offered. As explained in Part I, thanks to the ACA, lower-income workers have access to highly subsidized health insurance on the exchanges.⁸⁶ On one hand, if an employee can get cheaper and/or more generous coverage than she would have received from her employer via the exchanges the employer's decision not to offer benefits will not have a harmful impact. Paradoxically, the employee might actually end up better off in the long run. (She will of course have to deal with administrative hassle of having to switch insurance carriers, which could disrupt her access to health care, particularly if it occurs mid-treatment.) On the other hand, if an individual does not qualify for the tax credit or other government benefits and/or the coverage available to her on the exchanges is less comprehensive, the absence of employer-provided benefits might deny her access to health care. For example, a person without employer-provided benefits who finds herself in the Medicaid gap could end up without meaningful access to health care.⁸⁷ Of course, another factor to consider is that policies

⁸¹ Moore, *Pay or Play*, *supra* note 51.

⁸² However, a recent article in Health Affairs only found marginal evidence in favor of an increased reliance on part-time workers. See Asako S. Moriya, Thomas M. Selden, & Kosali I. Simon, *Little Change Seen In Part-Time Employment As A Result Of The Affordable Care Act*, 35 HEALTH AFFAIRS 119 (2016).

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Merlis, *supra* note 45, at 1. That said, the tax penalties are not themselves tax deductible, while the premiums are, which means that the penalties could be substantially larger than they first appear.

⁸⁶ *Supra* note 52 and accompanying text.

⁸⁷ Medicaid may also be an option for some but with the piecemeal enactment of the Medicaid expansion and the gap it creates between public benefits and the availability of subsidies in some states, people may find themselves in a

purchased on the exchanges are not tax-deductible, while employer-provided benefits are (at least to a point), which may also affect the relative desirability of an exchange policy versus an employer-provided one.

2. Targeted Employee Dumping

An employer could also act as a gatekeeper by excluding certain employees. But why would employers want to offer health insurance to some employees but not others? The answer is simple: cost. By denying benefits to potentially expensive employees, employers can theoretically save on health insurance costs. Moreover, employers can make themselves more competitive by passing on some of the savings to workers in the form of higher pay. Amy Monahan and Dan Schwarcz refer to this practice as “targeted dumping.”⁸⁸ Employers can engage in both explicit and in structural employee dumping behaviors.

Explicit dumping practices are relatively straightforward. An employer who does not wish to offer insurance to a potentially expensive employee could fire her, switch her to part-time or contract work to avoid the employer mandate, or not hire her to begin with. A handful of cases indicate that at least a few employers have engaged in this type of conduct.⁸⁹ Encouraging a potentially expensive employee to voluntarily leave a health plan is a less dramatic explicit dumping strategy. For example, one woman reported that after she had prophylactic surgeries due to a heightened genetic risk of breast cancer, her boss yelled at her at work for increasing the yearly cost of the health policy by \$13,000, asked her to switch to her husband’s insurance, and offered her additional compensation to leave the employer-provided plan.⁹⁰

In addition to explicit employee dumping, employers may also adopt subtler strategies specifically geared to shunt potentially costly individuals off their health plans. I call this phenomenon “structural

Goldilocks dilemma. They could be too poor to afford health insurance yet too wealthy to qualify for Medicaid or the low-income subsidy.

⁸⁸ Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 128 (2011) [hereinafter *Dumping*].

⁸⁹ See JESSICA L. ROBERTS & ELIZABETH WEEKS LEONARD, *HEALTHISM: HEALTH-STATUS DISCRIMINATION & THE LAW* (forthcoming Cambridge University Press 2018).

⁹⁰ SEC’Y’S ADVISORY COMM. ON GENETICS, HEALTH, & SOC’Y, U.S. DEP’T OF HEALTH & HUMAN SERVS PUBLIC PERSPECTIVES ON GENETIC DISCRIMINATION: SEC’Y’S ADVISORY COMM. ON GENETICS, HEALTH, & SOC’Y 14-15 (2004).

employee dumping.” This variety of targeted dumping operates through “subtle, informal pressure” not outright coercion.⁹¹ Monahan and Schwarcz explain that employers can dump potentially expensive employees from their health plans using “indirect risk classification.” Indirect risk classification does not rely upon the employer’s differentiating between high and low-risk employees but rather creates situations in which the individuals themselves will self-classify based on risk through their decisions related to health insurance.⁹²

Employers can achieve this goal through both positive and negative signals. On one hand, they could adopt plans that offer significant benefits related to wellness, such as joining a gym or maintaining a healthy blood pressure or weight, thereby encouraging low-risk employees to accept coverage.⁹³ On the other, the plans could include high deductibles and exclude drugs and treatments associated with chronic conditions, thus creating incentives for high-risk employees to seek health insurance elsewhere.⁹⁴

Employers could also go as far as advising their high-risk employees that those individuals may have better coverage going through the exchanges.⁹⁵ Thus, after adopting policies with elements designed to attract low-risk employees and discourage high-risk ones, employers can explain to the high-risk employees why it is in their self-interest not to accept the employer-provided plan because outside health insurance would better meet their medical needs. Remarkably, the ACA does very little to combat targeted dumping, especially by self-insured employers.⁹⁶ Despite the polarized reaction to health-care reform, Monahan and Schwarcz argue that people of all political and ideological stripes should agree that gaming the system through targeted dumping is an undesirable outcome.⁹⁷

Like the impact of the decision whether to offer benefits, the effect of targeted employee dumping also depends on the individual employee’s income (i.e., access to subsidies) and the relative desirability of the policies available on the exchanges as compared to the policies provided by the employer. If a dumped individual can access more affordable and/or expansive coverage on the exchanges, the effect could be neutral, even

⁹¹ Monahan & Schwarcz, *Dumping*, *supra* note 88, at 171.

⁹² *Id.* at 134-35.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.* at 171.

⁹⁶ *Id.* at 146.

⁹⁷ *Id.* at 132.

preferable. If she cannot, it is problematic. Moreover, it is worth noting that dumping that affects employment, such as failing to hire, firing, or switching to part-time or contract work, will have the added negative impact of reducing the wages available to purchase health care out-of-pocket.

B. EMPLOYERS AS REGULATORS

Employers' gatekeeping function is all-or-nothing: Either the employee has access to meaningful employer-provided coverage, or she does not. If an individual without employer-provided benefits also cannot obtain coverage on the exchanges or afford to purchase health care on her own, she may find herself effectively shut out of the health-care system. Yet as regulators, employers make decisions that have a more subtle impact on health-care access by shaping the conditions under which their employees obtain care.⁹⁸ In other words, they can affect *how* their employees access health care. The affected individuals could end up under-insured—that is they nominally hold health insurance but are still unable to access needed health care—or they might choose one treatment option or medical professional over another, not for health related reasons but because of their coverage. This Sub-Part explores three ways in which employers regulate health-care access: plan structure; scope of coverage; and cost-sharing.⁹⁹

1. Plan Structure

The types of plans employers choose to offer their employees shape how those covered individuals access the health-care system. Employers may choose from a variety of benefits structures when offering

⁹⁸ See Abigail R. Moncrieff, *The Individual Mandate as Healthcare Regulation: What the Obama Administration Should Have Said in NFIB v. Sebelius*, 39 AMER. J. L. & MED. 539, 541 (2013) (explaining that health insurance “imposes regulatory constraints on individual consumption decisions, steering beneficiaries toward particular goods and services”).

⁹⁹ Matthew identified a similar list of strategies. Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Markets, Courts and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1045-49 (1996) (identifying four major approaches that employers have taken to manage health insurance costs). Matthew cites adopting plans with cost-sharing provisions, limiting coverage for costly individuals, self-insuring, and opting not to offer coverage. *Id.*

health-insurance coverage to their employees. Typical health plan structures include indemnity plans, preferred provider organizations (PPOs), point-of-service plans (POSs), health maintenance organizations (HMOs), and finally accountable care organizations (ACOs). Yet while employers enjoy significant choice in selecting which health plans to offer they tend to provide only one or two options to their employees.¹⁰⁰

Indemnity plans are the simplest. They indemnify the insured from the costs of health care.¹⁰¹ Few cost-limiting mechanisms existed under such plans and the insurance company typically paid on the billed amount, leaving the provider to recoup any additional costs from the insured.¹⁰² While these kinds of plans were common before the managed-care revolution of the 1980s and early 1990s, they now make up only one percent of the current health-insurance market.¹⁰³

Common plan structures include PPOs, HMOs, POSs, and ACOs. PPOs are currently the most popular variety of managed-care plans.¹⁰⁴ PPOs contract with a network of “preferred” health-care providers who agree to the plan’s payment structure.¹⁰⁵ The PPO pays the providers directly for their services.¹⁰⁶ HMOs not only handle benefits coverage but also create and maintain the very health-care delivery system itself.¹⁰⁷ The vast majority of HMOs contract with health systems and hospitals directly.¹⁰⁸ Because they are licensed by the states, HMOs must comply with more rules and regulations than other types of plans, such as providing adequate access to health-care providers and permitting direct access to PCPs.¹⁰⁹ Importantly, HMOs typically share some degree of risk with their physician network.¹¹⁰ POSs combine characteristics of managed-care and indemnity plans by allowing insureds to choose which type of benefits they want to use when they access health care, or at the “point of service.”¹¹¹ These plans allow employers to capitalize on the cost-savings of an HMO-

¹⁰⁰ Margaux J. Hall, *A Fiduciary Theory of Health Entitlements*, 35 *CARDOZO L. REV.* 1729, 1741 (2014); Robertson, *Cost-Sharing*, *supra* note 145.

¹⁰¹ PETER R. KONGSTVEDT, *ESSENTIALS OF MANAGED HEALTH CARE* (2012).

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

style plan while still allowing some coverage for out-of-network health-care services.¹¹² Finally, because of the backlash against traditional managed care organizations, the ACA ushered in a new variety of managed care: ACOs.¹¹³ As with HMOs, in ACOs, participating providers agree to share the responsibility for a group of patients in terms of both financial risk and health-care delivery.¹¹⁴ However, ACOs differ from HMOs because they are provider-led and are designed to guarantee both efficient and effective care. While the primary payment incentives with respect to HMOs are financial, ACOs also introduce a quality standard. ACOs adopt an alternate payment structure designed not only to reward economic efficiency but also quality of care.¹¹⁵

The type of plan an employer selects can have a direct effect on how its employees access health care. For example, in a PPO, insureds who seek care in network receive certain benefits,¹¹⁶ thereby pushing them toward the providers who have agreed to the terms of the PPO. If a person's top choice of health-care provider has not agreed to the terms of the PPO, that individual may be inclined to instead seek care in-network. PPOs therefore limit individual choice and shape where insureds ultimately access health care. Similarly, the indemnity-style coverage of POSs tends to incorporate steep cost-sharing mechanisms to encourage individuals to seek care in network.¹¹⁷ Further, to access the highest degree of coverage for non-emergency treatment, individuals in POSs must first go through their primary-care physician (PCP).¹¹⁸ Hence, like PPOs, POSs push individuals toward certain providers. Additionally, requiring a PCP visit prior to specialty care structures the way in which insureds access health care by restricting their ability to independently seek care from specialists.

HMOs, like the other kinds of managed-care plans, also restrict where insureds can access health care. Even post-ACA, employers—self-insured and otherwise—are more or less able to craft their provider networks however they choose.¹¹⁹ Those choices can have far-reaching implications for patient access. Frequently, participants must access care in network and must go through a designated PCP before obtaining

¹¹² *Id.*

¹¹³ See generally Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat it Too?*, 42 SETON HALL L. REV. 1393 (2012)

¹¹⁴ *Id.* at 1410-12.

¹¹⁵ *Id.* at 1410.

¹¹⁶ KONGSTVEDT, *supra* note 101.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ Monahan & Schwarcz, *Dumping*, *supra* note 88, at 149.

specialized care.¹²⁰ Seeing out-of-network specialists may prove particularly challenging. For example, the plan might require PCP pre-approval or a referral from an in network provider or might cap the number of times that a participant can see an out-of-network specialist.¹²¹ Thus, insureds face two types of limitations. First, to fully enjoy the benefit of their health-insurance coverage they must seek care from a predetermined group of health-care providers, regardless of whether a physician outside the network could better meet their needs. Second, they cannot simply see a particular doctor—in network or not—when they please. They must go through the steps of acquiring referrals or pre-approvals to be covered in many circumstances. These restrictions significantly limit patients in their choices of which provider they see and when they see them. And that is no accident. Managed care plans are designed to funnel patients to particular clinics and physicians and through particular treatment channels to keep costs low. However, increasingly narrow networks can have a negative effect on health-care access, especially for the very sick.¹²²

Moreover, given the payment structure and risk-sharing aspects of HMOs, physicians have incentives to favor lower cost treatment options for the patients.¹²³ Capitation, a common mechanism for encouraging health-care providers to cut costs, can have a restrictive effect on health-care access.¹²⁴ Pursuant to a capitation regime, the insurer gives the physician a predetermined amount of money for treating a plan participant over a particular time span.¹²⁵ If the treatment costs are less than the payment, the physician keeps the overage.¹²⁶ If they are more, the physician receives no additional compensation.¹²⁷ Clearly, the incentive is to provide health care at as little cost as possible to retain the maximum share of the capitation payment. Therefore, a doctor may not recommend a particular procedure or course of treatment—even if it has therapeutic benefit—thereby restricting the patient’s choice of covered treatment options. Moreover, a patient may not even *know* a treatment alternative exists if she depends on

¹²⁰ *Id.* at 168.

¹²¹ *Id.*

¹²² See generally Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 63 (2015).

¹²³ Bronsteen et al., *supra* note 49, at 2318.

¹²⁴ KONGSTVEDT, *supra* note 101.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

her physician to inform her.¹²⁸ This scenario is particularly problematic because the patient, being unaware of the full panoply of possible treatments, does not even have the choice to pay out-of-pocket for a more expensive option. As a result, the use of financial incentives to encourage health-care providers to factor cost into their treatment recommendations has been cited as an example of the agency problems described in Part III.¹²⁹ ACOs may also encourage health-care providers to offer less expensive treatment options, thereby restricting choice in health care and, as a result, potentially denying patients access to medically beneficial care.¹³⁰

In sum, the types of plans employers choose to offer their employees can have a significant impact on the conditions under which those individuals access health care. In particular, the plan structure can dictate which kinds of medical professionals a person can consult, when, and for what price.¹³¹ These constraints are designed primarily to reduce costs, including wasteful medical spending, but not necessarily to ensure access or improve health-care delivery.

2. Scope of Coverage

Employers have discretion with respect to the scope of the benefits they offer. Small-group insurers, like those on the individual market, must offer federally determined essential health benefits.¹³² Although large employer-provided and self-insured plans need not provide all ten of the essential benefits like their individual and small-group compatriots, they are subject to certain requirements in terms of both coverage and affordability.¹³³ However, because coverage and affordability are both

¹²⁸ *Id.*

¹²⁹ *Id.*; Bronsteen et al., *supra* note 49, at 2317 (asserting that such systems could “incentivize physicians to underprovide care”).

¹³⁰ Mantel, *supra* note 113, at 1427. Of course, more expensive treatment is not necessarily better.

¹³¹ Moncrieff, *supra* note 98, at 552-53 (describing ways in which insurance coverage shapes health-care decisions through its pricing structure and administrative requirements).

¹³² Specifically, the ACA imposes coverage requirements on plans in the individual and small-group markets. See Monahan & Schwarcz, *Saving*, *supra* note 56, at 1945-46.

¹³³ See Allison Hoffman, *Health Care Spending and Financial Security After the Affordable Care Act*, 92 N.C. L. REV. 101 (2014) [*hereinafter Health Care Spending*] (describing the relatively loose regulation of employer-provided health

described in terms of the cost of the plan, those requirements do not mandate particular substantive benefits.¹³⁴ Thus, large-group and self-insured employer-provided plans maintain significant freedom regarding what they choose to cover.¹³⁵ As Amy Monahan and Dan Schwarcz point out, a self-insured employer could lawfully implement a health plan that covers *only* preventive services, the four types of coverage mandated by ERISA, and the routine costs of individuals in clinical trials.¹³⁶ Nothing more. It is also worth noting that because of the notorious promise that “if you like the plan you have, you can keep it,”¹³⁷ plans that do not comply with the ACA’s requirements but were in effect before March 23, 2010 have grandfathered status.¹³⁸ Hence, while the ACA does impose some substantive requirements on certain types of policies, it leaves a fair amount of discretion for certain kinds of employers.¹³⁹

Given the leeway described above, employers with self-insured or large-group plans that wish to limit coverage—either for financial or, as in *Hobby Lobby*, ideological reasons—could do so in a variety of ways. For example, many health insurance policies both limit their coverage to medically necessary treatment (the determination of which may be left to the insurer’s discretion) and exclude experimental options.¹⁴⁰ Employers can also select plans that do not cover the treatment of certain conditions.

insurance under the ACA). Hoffman proposes that by banning caps, the ACA could actually discourage employers from adopting plans that cover essential benefits. *Id.*

¹³⁴ Monahan & Schwarcz, *Dumping*, *supra* note 88, at 158 (explaining that neither “affordable” or “minimum value” apply to the scope of the benefits provided).

¹³⁵ *Id.* at 147

¹³⁶ *Id.* at 148.

¹³⁷ See Administration of Barack Obama, Statement on the Third Anniversary of the Signing of the Patient Protection and Affordable Care Act, (Mar. 23, 2013).

¹³⁸ ACA, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161-62 (codified as amended at 42 U.S.C. § 18011). Grandfathered plans can continue to impose restrictions on coverage such as preexisting condition exclusions and annual and lifetime caps. Yet plans can very easily lose their grandfathered status by adopting any number of changes. Merlis, *supra* note 45, at 3.

¹³⁹ Yet where the ACA falls short in terms of benefits regulation, state law may do some work. Although ERISA prevents states from regulating self-insured plans, it specifically allows them to impose substantive requirements on health insurers who provide insurance to employers and states have availed themselves of the opportunity by requiring insurers to cover a significant range of benefits. Monahan & Schwarcz, *Dumping*, *supra* note 88, at 144.

¹⁴⁰ Bronsteen et al., *supra* note 49, at 2316

They could, therefore, select or design plans that exclude drugs and care for stigmatized or especially costly health problems, such as AIDS and hemophilia.¹⁴¹ Yet even when they provide coverage for a particular condition, employers and health insurers may only cover certain options for treating that condition. Likewise, a policy may cover only one course of treatment or one aspect of the treatment process. A policy could, therefore, cover tests for autism while excluding the behavioral therapy needed for long-term management and care, or simply cap coverage for a given condition at a particular amount.¹⁴² Given the discretionary and patchwork nature of certain health plans, it is not terribly surprising that many individuals with cancer report that their employer-provided plans fail to comprehensively cover their treatment.¹⁴³ Because employees have little choice with respect to the content of their employer-provided plans, which in turn leads to little incentive to actually read coverage details carefully, they frequently are unaware of these gaps in benefits. Sadly, many times, it is not until an individual or her family falls ill that she discovers she lacks coverage for a needed treatment.¹⁴⁴

The scope of coverage an employer offers can affect access. First, individuals may forgo potentially beneficial treatments or services because they are not covered and the employees cannot afford to pay out-of-pocket. Treatments or services with therapeutic value may not be “medically necessary.” Thus, even if an individual could benefit from health-care services, if the insurer deems the services unnecessary or experimental, that person may not be able to access them. Second, individuals may be uninsured for certain conditions. When an employer chooses a plan that does not cover a particular health condition, a covered employee may not seek any treatment because she cannot afford it without the help of insurance. The absence of any meaningful treatment options raises gatekeeping concerns. Finally, individuals may make treatment decisions based on coverage instead of medical opinion. For example, a person

¹⁴¹ See Monahan & Schwarcz, *Dumping*, *supra* note 88, at 147.

¹⁴² See *id.* at 166. Such caps could lead employees to begin treatment that they must eventually abandon once they reach the cap. Hoffman, *Health Care Spending*, *supra* note 133.

¹⁴³ S. Yousuf Zafar et al., *The Financial Toxicity of Cancer Treatment: A Pilot Study Assessing Out-of-Pocket Expenses and the Insured Cancer Patient's Experience*, THE ONCOLOGIST (2013); see also Henry J. Kaiser Foundation, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System*, Jan. 30, 2009, available at <http://kff.org/health-costs/event/spending-to-survive-cancer-patients-confront-holes/>.

¹⁴⁴ Matthew, *supra* note 99, at 1048.

might choose drug therapy over surgery even when surgery is the most desirable treatment option. While they may not be as harmful as outright exclusion, such limitations on substantive health-insurance benefits provide yet another example of how employers' decisions ultimately dictate health-care access.

3. Cost-Sharing

Cost-sharing mechanisms can also affect health-care access. Cost-sharing provisions, such as including deductibles, co-payments, and co-insurance, require individuals to pay some amount out-of-pocket to access the covered health care.¹⁴⁵ The major aim of these kinds of measures is to reduce wasteful spending by ensuring that people have skin in the game. However, the same mechanisms could also discourage obtaining needed medical treatments because of cost.

The ACA also creates some restrictions on cost-sharing. For instance, the law requires coverage with no cost-sharing for certain preventive services, such as immunizations depending upon age and population, as well as screenings (and sometimes counseling) for various conditions, including alcohol misuse, diabetes, HIV, and depression.¹⁴⁶ Thus, employer-provided plans can theoretically no longer cut costs by passing a portion of those particular kinds of expenses down to the employees. However, they may pass costs down to employees by making them pay more for coverage or by skimping in other areas. The ACA also limits the maximum amount an individual can contribute in cost-sharing obligations for essential benefits in individual and small group plans on the exchanges, as well as employer-provided group plans,¹⁴⁷ and caps cost-

¹⁴⁵ Because individuals must pay up to a certain threshold before accessing their benefits, Christopher Robertson has aptly described cost-sharing mechanisms as “just the absence of insurance for certain costs.” Christopher T. Robertson, *Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security*, 14 *YALE J. HEALTH POL'Y, L., & ETHICS* 239 (2014) [hereinafter *Cost-Sharing*]; see also Moore, *Pay or Play*, *supra* note 51; Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform*, *YALE J. HEALTH POL'Y, L., & ETHICS* 453, 457 (2009).

¹⁴⁶ ACA, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 131-32 (codified at 42 U.S.C. § 300gg-13); Dep't of Health and Human Servs., Preventative Services Covered Under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>.

¹⁴⁷ ACA, Pub. L. No. 111-148, § 1302(c), 124 Stat. 119, 165-167 (codified as amended 42 U.S.C. § 18022).

sharing for individual and small-group plans.¹⁴⁸ Despite those restrictions, it seems that health-care reform has actually encouraged many employer-provided health plans to increase their adoption of cost-sharing devices. Following the ACA, employers may start to move away from managed-care plans, which carry with them lower out-of-pocket costs, to higher deductible and co-pay plans.¹⁴⁹

Cost-sharing mechanisms can shape how individuals access health care because high deductibles and co-pays may discourage them from seeking medical treatment when they actually need it.¹⁵⁰ Importantly, cost-sharing mechanisms affect workers differently. For example, a \$5000 annual deductible is of a higher relative cost to an employee that makes \$20,000 per year as compared to an employee who makes \$100,000. Thus, while deceptively facially neutral, a co-pay or deductible that fits comfortably within the price range of one employee might be too expensive for another. As a result, some individuals may nominally hold health insurance from their employers but still be unable to meaningfully access the health-care system, leaving them under-insured.¹⁵¹ To cope with this under-insurance, they may allocate money away from other necessities¹⁵² or forgo needed care altogether.¹⁵³ Hence, from a practical perspective,

¹⁴⁸ ACA, Pub. L. No. 111-148, § 1302(c)(1), 124 Stat. 119 (codified as amended at 26 U.S.C. § 18022(c)(1)) (citing 26 U.S.C. § 223(c)(2)(A)(ii)); *see also* Monahan & Schwarcz, *Saving*, *supra* note 56, at 1946. Interestingly, the ACA also originally included a provision that would have applied only to small-group plans, forbidding deductibles that exceed two and four thousand dollars for individual and family coverage, respectively, but it was repealed. *See* ACA, Pub. L. No. 111-148, § 1302(c)(2)(A), 124 Stat. 119, 166 (repealed 2014); *see also* Monahan & Schwarcz, *Saving*, *supra* note 56, at 1946.

¹⁴⁹ John Ydstie, *More U.S. Companies Switch to High Deductible Health Plans*, NPR (Feb. 18, 2014) <http://www.npr.org/2014/02/18/278952305/there-s-hope-health-care-costs-can-be-brought-under-control> (citing Tom Mangan).

¹⁵⁰ Proponents of these plans contend that the benefits of discouraging insureds from seeking care that significantly exceeds their benefits outweighs these potential detriments.

¹⁵¹ The differing impacts of cost-sharing also create distortions on the other side. Affluent people end up over-insured because the cost-sharing mechanisms are not set high enough to deter them from spending and all of the care over the threshold amount is fully covered. Robertson has proposed a straightforward, elegant solution to this problem: scaled cost-sharing. Under such a system, cost-sharing obligations would vary depending on an individual's ability to pay. Robertson, *Cost-Sharing*, *supra* note 145.

¹⁵² *Id.* at 250-51.

¹⁵³ *Id.* at 252.

being under-insured can be just as harmful as being uninsured.¹⁵⁴ Not surprisingly, cost-sharing mechanisms, therefore, have a disproportionately negative effect on the chronically ill¹⁵⁵ and the disabled.¹⁵⁶

* * *

Viewed through the lens of employer-provided benefits, the real problem of *Burwell v. Hobby Lobby* is not that employers' religious freedom may conflict with employees' reproductive rights, but rather that private employers play a dominant role in many Americans' access to health care. After having outlined the ways in which employers shape health-care access, Part III proposes that less reliance on employers to provide health insurance could help end their reign as de facto health-care policy makers.

III. GOING FORWARD

Hobby Lobby can be understood as being about much more than just access to contraception. Employers act as both gatekeepers and regulators of the health-care system. So if a woman's job should not have anything to do with her decisions about her reproductive health, then arguably her job should not have any bearing on which doctors she sees or which treatment she chooses. Likewise, it is unclear why private employers should offer health insurance to their employees that conflicts with their financial or ideological interests. Thus, the real solution to the *Hobby Lobby* problem might be a move away from the employer-provided benefits system. Part III begins with a brief defense of employers and then turns to the uncertain future of employer-provided benefits in the wake of health-care reform.

A. A BRIEF DEFENSE OF EMPLOYERS

If viewed as an employer-provided benefits case, the issue in *Hobby Lobby* becomes a classic agency problem. When administering

¹⁵⁴ *Id.* at 251-52 (asserting that "being severely underinsured is the same as being uninsured, as the empirical evidence about the consumption behavior of these two groups demonstrates").

¹⁵⁵ Pendo, *supra* note 145, at 457-58.

¹⁵⁶ Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963, 1972 (2013).

health plans, employers act as their employees' agents. But employer and employee interests may not align, either economically or ideologically. As predominantly private entities, employers tend to be more interested in their business operations than the promotion of public health.¹⁵⁷ Because it is frequently in employers' best interests to keep costs low,¹⁵⁸ employers have strong financial incentives to construct their benefits to avoid legal penalties, such as those in the ACA's pay-or-play provisions, while reaping potential benefits, tax or otherwise, whenever possible. Moreover, employers may have certain ideologies. While this claim is most clear in the case of sole proprietorships—where the person and the business are one in the same—*Hobby Lobby* illustrated that corporate persons are made up of actual persons, whose beliefs may also affect how they want to run their business. These efficiency- and ideology-driven interests can impact the kinds of health-insurance benefits that employers offer their workers.

¹⁵⁷ Long before the ACA, Dayna Matthew explained: “[L]egislators, and to a lesser degree the courts interpreting these statutes, have essentially appointed employers their agents to serve a broad social ideal: to provide health insurance coverage and, therefore, health care access to all working Americans, on a non-discriminatory, virtually non-contributory basis.” Matthew, *supra* note 99, at 1066. However, employers often act with self-interest. See Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance under the ACA*, 31 YALE L. & POL’Y REV. 275, 283 (2013) (explaining that “the employer-sponsored insurance regime involves voluntary promises undertaken by actors motivated by self interest”). While Matthew published her Essay in 1996, almost twenty years later her observations still ring true:

Current regulatory controls miss the mark by not reckoning with the fact that employers are increasingly unable to satisfy both the weighty social goal that has been imposed upon them—ensuring that all working Americans are guaranteed minimal access to health care—and their obligation to serve their own business interests. Thus, it is not only employees that incur significant agency costs under the employment-based health insurance system, but to the extent that we collectively depend upon employers to serve health policy objectives through this system, these costs are borne by the rest of society as well.

Matthew, *supra* note 99, at 1040-41.

¹⁵⁸ Matthew, *supra* note 99, at 1038 (“Assuming employers are . . . rational utility maximizers, their objective is to minimize the cost of obtaining the level and quality of health insurance that the labor market, relevant to the employer’s enterprise, demands.”).

Employers are not villains here: An employer's primary function is not providing health insurance. Their cost-reducing strategies may be economically rational and their ideological beliefs may be sincerely held. Thus, employers find themselves in a sticky situation. On one hand, the health plans they provide are a key instrument of health-care reform's effort to expand access. Yet on the other, they have businesses to run and are composed of people with personal lives and beliefs. These competing loyalties have not gone unnoticed. Early in the history of employer-provided benefits, the Supreme Court acknowledged that, when administering an insurance plan, employers rightly serve the interests of both themselves and their employees.¹⁵⁹ The question then becomes how to properly balance these competing concerns.

One way to think of this possible conflict of interest is in agency terms.¹⁶⁰ To invoke the agency model, one party must be entrusted with serving the interests of another. Commentators have traced an employer's duty to act on behalf of its employees when administering health insurance to its obligations under ERISA¹⁶¹ and the ACA¹⁶² and to the common

¹⁵⁹ See *Boseman v. Conn. Gen. Life. Ins.*, 301 U.S. 196, 204 (1937) ("When procuring the policy, obtaining applications of employees, taking payroll deduction orders, reporting changes in the insured group, paying premiums and generally in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer but for their employees and for themselves.").

¹⁶⁰ See, e.g., Bronsteen et al., *supra* note 49; Hall, *supra* note 99; Matthew, *supra* note 98, at 1038 (asserting that "the agency model best explains the nature of, and problems presented by, the employment-based health insurance system"). However, the agency model is not the only way to understand the relationship between employers and employees with respect to health insurance. See Matthew, *supra* note 98, at 1039 ("One might conclude the employment-based insurance system is not an agency problem at all, but rather a contract relationship in which one party undertakes to resolve a classic collective action problem incident to the terms of the contract.").

¹⁶¹ Bronsteen et al. explain that an ERISA plan is effectively a quasi-trust, thereby giving rise to all of the associated obligations. Bronsteen et al., *supra* note 49, at 2304 ("Indeed, an ERISA benefit plan is, in design and practice, a form of statutory quasi trust administered by the employer (or its designees) as a fiduciary for the employee. Whatever the extent of ERISA's overlap with trust law, it is undeniable that an ERISA benefit plan creates (in economic terms) an agency relationship: the principal (i.e., the plan participant) relies on the agent (i.e., the plan fiduciary) to protect and advance the principal's interest.").

¹⁶² Hall identifies both pre- and post-ACA health entitlements. Hall, *supra* note 100, at 1745-54.

law.¹⁶³ If employers act as fiduciaries, they would then owe their employees the duties of loyalty and care.¹⁶⁴ Yet, with any agency relationship comes the potential for agency problems: Will the agent truly prioritize the interests of the principal?¹⁶⁵ Given the importance of health insurance in ensuring health-care access¹⁶⁶ and the fact that employer-provided benefits are often determined pre-employment, effectively making them contracts of adhesion,¹⁶⁷ employees are particularly vulnerable principals. Employees must rely on their employers to select the very benefits that will determine whether and how they obtain health care. Specifically, the relationship generates agency costs because at times the interests of employer-agent and the employee-principal will diverge.¹⁶⁸

It is worth pausing to note that agency costs are not inevitable. They only occur when the agent's and the principal's priorities do not align. Sometimes, however, employer and employee health-insurance interests converge. For example, a large employer acting on behalf of its employees has more bargaining clout and can therefore negotiate better rates and terms—as well as advocate more zealously in the event of a

¹⁶³ Matthew, however, asserts that the agency relationship “arises between employer and employee when, upon accepting a job in which health insurance benefits represent a portion of the compensation package, an employee engages his employer to perform the service of purchasing and administering a health insurance plan on his behalf.” Matthew, *supra* note 99, at 1038. As a result, according to Matthew, “courts impose a general responsibility, akin to a fiduciary duty, upon employers administering health insurance plans for their employees.” *Id.* at 1054; *see also* Dawes Mining Co. v. Callahan, 272 S.E.2d 267, 269 (Ga. 1980) (holding that “in procuring the group policy and obtaining employee applications, the employer acts as an agent of the employees where the employees will be contributing toward payment of the premium”).

¹⁶⁴ Bronsteen et al., *supra* note 49, at 2304; Hall, *supra* note 99, at 1763-65 (discussing the duties of loyalty and care). However, it is worth noting that while scholars and courts may view employers as fiduciaries with respect to their health-insurance plans, the employers themselves may not share that perspective. *See* Matthew, *supra* note 98, at 1041 (“Employers do not perceive themselves or behave as their employees’ agents in the insurance market.”).

¹⁶⁵ Bronsteen et al., *supra* note 49, at 2304.

¹⁶⁶ *See* Part I.B., *supra*.

¹⁶⁷ Bronsteen et al., *supra* note 49, at 2320.

¹⁶⁸ *See id.* at 2299 (defining “agency cost” as “the cost arising from a system that gives an agent the incentive to act contrary to the interests of its principal”). Likewise Matthew explains, “Costs are generated by this agency relationship, like all others, because employers’ objectives will diverge from the objectives of their employee-principals.” Matthew, *supra* note 99, at 1038.

dispute—than most employees acting on their own.¹⁶⁹ Also the employer-provided benefits system saves individuals a fair amount of time and hassle. Employees do not have to seek out health insurance or pay brokers; instead, upon employment, they receive a plan—or choice of plan from a heavily restricted menu of options—that has already been negotiated, purchased, and administered on their behalf.¹⁷⁰ Allowing an employer to act as an employee’s health-insurance agent thereby delivers some measure of administrative ease and convenience. From this perspective, a limited number of plans could actually be a benefit of the employer-provided health-insurance system because it simplifies the decision-making process.¹⁷¹ Admittedly, many of the historically cited benefits of the employer-provided system, such as collective negotiation and a limited number of possible choices for insureds, are likewise present when purchasing policies on the exchanges. Regardless, even when serving their own interests, under some circumstances, employers may act as excellent agents for their employees.¹⁷²

Despite the lower cost and administrative advantages of employer-provided health insurance, evidence indicates that employers do not select the insurance that employees would choose for themselves.¹⁷³ Put differently, employers and employees have different views regarding what health insurance is “optimal.”¹⁷⁴ Further complicating matters is that the employer acts as the agent of multiple principals, each who may have

¹⁶⁹ Matthew, *supra* note 99, at 1043; Moore, *Employment-Based*, *supra* note 50, at 897.

¹⁷⁰ Matthew, *supra* note 99, at 1043; *see also* Moore, *Employment-Based*, *supra* note 50, at 896-97 (explaining how the employer-provided benefits system saves employees transaction costs).

¹⁷¹ *See* Moore, *Employment-Based*, *supra* note 50, at 897 (asserting that “[e]mployers assist employees by offering employees a limited choice among plans”).

¹⁷² *See* Matthew, *supra* note 99, at 1040 (“Employers act in their entrepreneurial self-interest, purchasing health insurance under terms which may also benefit and serve the employees’ needs and interests as well.”). Research confirms this outcome. *See* Moore, *Employment-Based*, *supra* note 50, at 897 (citing Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 *MILBANK Q.* 5 (2000)).

¹⁷³ Matthew, *supra* note 99, at 1056 (stating that “employers’ and employees’ demand curves for health insurance are distinctive”); *id.* at 1061 (asserting that “employers, acting as agents for their employees, will make different health insurance choices than employee representatives will make for themselves”).

¹⁷⁴ *Id.* at 1057.

different needs. For instance, it may be in the best interests of one set of employees to have comprehensive coverage with large networks that lack financial incentives to lower spending but another set of employees might prefer lower health-care costs so that they take home more in wages every month. Exacerbating this issue is the zero-sum nature of providing benefits—employers and insurers either grant benefits and pay or deny benefits and save—and the level of discretion left to providers in making those choices.¹⁷⁵

Of course, the agent-principal paradigm reduces the very complex interests at stake in the employer-provided benefits systems to a single vector: employee and employers. Several other parties could have a dog in this fight. Employers' desire to maximize profits could flow from a competing fiduciary relationship, company to shareholders. And the United States government itself has an interest in employer-provided health insurance, as it is a key part of the ACA's move toward universal coverage. Unfortunately, Congress's decision to vest private employers with the responsibility of insuring a significant portion of Americans perpetuates the intractable tension between the employers' interests, whether in efficiency and cost minimization or in practicing religion, and the government's desire to improve health-care access by expanding health-insurance coverage.

There is no need to tether health insurance to employment. Yet, none of the commentators in *Hobby Lobby*—or even the Supreme Court Justices themselves—questioned the link between work and health insurance. This silence reveals the tacit assumption that Americans are entitled to health insurance through their employers. However, this entitlement does not stem from a necessary relationship between health insurance and employment (if anything the agency issues described above undermine the wisdom of such a system) but rather the historical tendency of employers to offer health insurance in the first place. Maher explains that if a substantial number of people receive a particular good in conjunction with employment, they will conflate the practical connection between work and the good with a logical connection between work and the good.¹⁷⁶ In other words, the reality that so many employers *provide* health insurance translates to the belief that employer-provided health insurance is sensible. However, as this Essay has attempted to demonstrate, employers are not necessarily logical health-insurance

¹⁷⁵ Bronsteen et al., *supra* note 49, at 2311 (explaining that in the zero-sum game of benefits distribution “fiduciaries lose by granting benefits”).

¹⁷⁶ Maher, *supra* note 38.

providers. To that end, Maher poses the important question: “Why did the ACA promote, to some degree, the continued existence of [employer-provided] health insurance?”¹⁷⁷ While he notes some possible political and tax-based reasons, he concludes that “the legislation’s pro-[employer-provided benefits] bias was a questionable (although not indefensible) policy choice.”¹⁷⁸ To be sure, Congress could have avoided the kinds of agency problems described above if it had done away with the employer-provided benefits system.¹⁷⁹

B. UNCERTAIN FUTURE OF EMPLOYER-PROVIDED BENEFITS

At least one way to avoid future *Hobby Lobbys* would be to stop the American reliance on the employer-provided benefits. While such a drastic change will not likely come from Congress anytime soon, there is some reason to believe the employer-provided benefits system—at least as conceived by the ACA—is relatively uncertain, including the controversies surrounding the employer mandate and the potential effect other parts of the legislation might have on employers.

Through the employer mandate, as described in Part I, the ACA not only kept the employer-provided benefits system intact, it actually codified the American reliance on employers to provide health insurance. However, the mandate has not gone unchallenged. Originally, the employer mandate was set to take effect in 2014. Consequently, President Obama made headlines when he delayed its implementation until 2015 to allow employers more time to comply with the new law.¹⁸⁰ In a similar move, in February 2014, the White House announced that the employers on the

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ For additional arguments in favor of decoupling health insurance and employment, see Hadley Heath, *Disconnect Insurance from Employment*, REAL CLEAR POLICY BLOG, Feb. 7, 2014, http://www.realclearpolicy.com/articles/2014/02/07/disconnect_insurance_from_employment_828.html and Seth J. Chandler, *The Cons of the ACA*, ACA DEATH SPIRAL BLOG, May 29, 2015 (discussing the employer mandate), available at <http://acadeathspiral.org/2015/05/29/the-cons-of-the-aca/>.

¹⁸⁰ See, e.g., Juliet Eilperin & Amy Goldstein, *White House Delays Health Insurance Mandate for Medium-Sized Employers Until 2016*, WASH. POST, Feb. 10, 2014, available at 2014 WLNR 3711223; Robert Pear, *Further Delays for Employers in Health Law*, N.Y. TIMES, Feb. 11, 2014, available at <http://www.nytimes.com/2014/02/11/us/politics/health-insurance-enforcement-delayed-again-for-some-employers.html?r=0>.

lower end of the spectrum—employers with fifty to ninety-nine employees—would have until 2016 to institute the required changes.¹⁸¹ Similarly, employers of one hundred or more employees can escape the statutory penalties in 2015 by offering affordable policies to seventy—not ninety-five—percent of their full-time workers.¹⁸²

Opponents of the ACA have launched several strategies to attempt to undermine the employer mandate. In November 2014, House Speaker John Boehner, on behalf of the Republican members of the House, sued the secretaries of the Treasury and HHS and their respective departments, alleging that the Obama administration abused its executive power by twice delaying the implementation of the employer mandate.¹⁸³ Most recently, Burwell filed a motion to dismiss, the House responded, and she replied. The litigation is ongoing. Additionally, in early 2015, the House passed a bill that would redefine the full-time workweek from thirty to forty hours.¹⁸⁴ While champions of the legislation assert it is designed to protect workers from potential gaming by employers to avoid the mandate (as described in Part II), opponents view it as a way to undermine the employer mandate's application to some of the nation's more vulnerable workers, people who work under forty hours per week.¹⁸⁵ Economists estimate that if such a bill were to pass, one million Americans would lose their health-insurance coverage.¹⁸⁶ Those individuals would either end up with government-provided benefits or with no health insurance at all.¹⁸⁷ Such a development could balloon federal spending by over fifty billion dollars in the next ten years.¹⁸⁸ However, the bill's success seems highly unlikely. It

¹⁸¹ See 79 Fed. Reg. 8544 (Feb. 12, 2014)(to be codified at 26 C.F.R. pt. 1, 54, 301) (explaining the changes to the ACA's employer mandate provisions); see also Eilperin & Goldstein, *supra* note 180; Pear, *supra* note 180.

¹⁸² *Id.*

¹⁸³ The lawsuit also asserted that funds tied to the ACA's cost-sharing program were not authorized by Congress. Complaint, U.S. House of Rep. v. Burwell, No. 14-cv-01967 (79 F.Supp. 3d 1 (D.C. 2015)), http://pdfserver.amlaw.com/nlj/boehner_burwell_20141121.pdf.

¹⁸⁴ Jonathon Weisman, *House Fires Shot at Health Care Law, Seeking to Alter Critical Coverage Rule*, N.Y. TIMES (Jan. 9, 2015), available at <http://www.nytimes.com/2015/01/09/us/politics/house-fires-shot-at-health-care-law-seeking-to-alter-critical-coverage-rule.html>.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

has not garnered sufficient support in the Senate and President Obama has indicated he would veto it if the legislation made it to his desk.¹⁸⁹

Although ACA adversaries have taken direct shots at the law's reliance on employers to provide health insurance, certain provisions of the statute could also—perhaps inadvertently—move us away from the employer-provided system. Particularly the Cadillac tax, a forty percent excise tax on benefits over a particular threshold, could encourage employers to opt in favor of the no-offer penalty if the cost of providing benefits continues to rise.¹⁹⁰

* * *

When situated in the greater context of employer-provided benefits, instead of being the clash between reproductive freedom and religious rights, the central conflict of *Hobby Lobby* becomes employer interests versus employee interests. Whether ideological or economic, the employers who offer health insurance have different priorities than the employees who use those benefits. But that is not to say employers should be more selfless. After all, the primary function of an employer is not to provide health insurance. Thus, viewed from this perspective, *Hobby Lobby* looks more like a failure of the employer-provided benefits system than a victory for the religious right. Perhaps then the most sensible way to avoid future conflicts of this kind would be to eliminate our reliance on employers to provide health insurance. Yet given all of the difficulties surrounding the ACA, Congress is not likely to revisit this issue for quite a while. But in the meantime, we could see the prevalence of employer-provided benefits winding down, in part because of steadfast Republican challenges and in part because of the ACA's own provisions.

CONCLUSION

This Essay's central assertion is that *Burwell v. Hobby Lobby* is best understood as an employer-provided benefits case. The vast majority of Americans depend on health insurance to access health care. Employers are the primary providers of health insurance for the non-elderly. Tying health insurance to employment renders employers de facto health-care policy makers who unwittingly serve both gatekeeping and regulating functions.

¹⁸⁹ *Id.*

¹⁹⁰ Roberts, *supra* note 4.

While the ACA could have untethered health insurance from employment, instead it entrenched their relationship. Now certain employers must provide their workers with comprehensive, affordable health insurance or face a tax penalty. Yet while employers may offer health insurance to their employees, they are still private entities with interests—both financial and ideological—beyond providing comprehensive, cost-effective coverage. As long as we depend on employers to provide health insurance for millions of Americans, we will continue to see conflicts regarding the kinds of policies employees need and the kinds of policies employers are willing to provide.^w

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: WHAT DOES IT REALLY DO?

JOHN G. DAY¹

*“We have to pass the health care bill so you can find out what’s in it,”
Speaker Nancy Pelosi, March 10, 2010 on the floor of the House
of Representatives urging her colleagues to pass the ACA.*

INTRODUCTION

We are now well into full implementation of the Affordable Care Act and, despite some distinct improvements, the nation is learning to live with reduced expectations about the benefits of that legislation. The exchanges’ initial rollout was chaotic,² deductibles and co-pays are high on the cheaper individual plans sold on the exchanges,³ insurers on the exchanges are seeking rate hikes,⁴ and important state participation has not emerged as anticipated. As of March 2016, only 31 states plus the District of Columbia were participating in the ACA’s Medicaid expansion program

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² See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-15-238, HEALTHCARE.GOV: CMS HAS TAKEN STEPS TO ADDRESS PROBLEMS, BUT NEEDS TO FURTHER IMPLEMENT SYSTEMS DEVELOPMENT (2014), <http://www.gao.gov/assets/670/668834.pdf>.

³ See Robert Pear et al., *Cost of Coverage Under Affordable Care Act to Increase in 2015*, N.Y. TIMES, Nov. 14, 2014, http://www.nytimes.com/2014/11/15/us/politics/cost-of-coverage-under-affordable-care-act-to-increase-in-2015.html?_r=0. See generally GOV’T ACCOUNTABILITY OFFICE, GAO-15-312, PRIVATE HEALTH INSURANCE: EARLY EVIDENCE FINDS PREMIUM TAX CREDIT LIKELY CONTRIBUTED TO EXPANDED COVERAGE, BUT SOME LACK ACCESS TO AFFORDABLE PLANS (2015).

⁴ See Margot Sanger-Katz, *Get Ready for Higher Obamacare Rates Next Year*, N.Y. TIMES (May 6, 2016), http://www.nytimes.com/2016/05/07/upshot/get-ready-for-higher-obamacare-rates-next-year.html?_r=0.

while 19 states were not.⁵ In 2016, only 12 states and the District of Columbia had their own exchanges; fully 27 states participated in the federal exchange.⁶ Meanwhile, the White House delayed the effective date of the ACA's employer mandates following business community resistance.⁷ Many continue to resent the individual mandate⁸ despite the Supreme Court's decision upholding that mandate in 2012.⁹

Opponents have grown more shrill and much of the rhetoric, including over 50 "ceremonial" repeals of the ACA in the House as of June 2015,¹⁰ were geared towards making ACA's implementation shortfalls and misunderstandings of what the ACA does into a 2016 presidential campaign issue. Not only do many legislators not know or even care what

⁵ See STATUS OF STATE ACTION ON THE MEDICAID EXPANSION DECISION, KAISER FAMILY FOUND. (2016), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

⁶ See STATE HEALTH INSURANCE MARKETPLACE TYPES, 2016, KAISER FAMILY FOUND. (2016), <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/>. Four more states have federally supported marketplaces and 7 states have state partnership marketplaces. *Id.*

⁷ See EMPLOYER RESPONSIBILITY UNDER THE AFFORDABLE CARE ACT, KAISER FAMILY FOUND. (2015), <http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>. Strictly speaking, the ACA does not require employers to provide their employees with health insurance. However, large employers must pay penalties to the Internal Revenue Service if they do not provide affordable health insurance coverage to their workers. The Obama Administration delayed the original effective date of that employer mandate until January 1, 2015 for employers with at least 100 employees and until January 1, 2016 for employers with at least 50 to 99 employees. *Id.*

⁸ Under the ACA's individual mandate, individuals who can afford minimum essential health insurance but decide not to buy it must either qualify for a health coverage exemption or pay a penalty. The individual mandate went into effect on January 1, 2014. See 26 U.S.C. § 5000A (2015); HealthCare.gov, *The Fee you Pay if you Don't Have Health Coverage*, <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/>. For discussion of the continued resentment in some quarters toward the individual mandate, see Dante Atkins, *King v. Burwell Unpopular, but Anti-ACA Propaganda Having Lasting Effects*, DAILY KOS (Apr. 12, 2015), <http://www.dailykos.com/story/2015/04/12/1376255/-King-v-Burwell-unpopular-but-anti-ACA-propaganda-having-lasting-effects>.

⁹ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012).

¹⁰ See, e.g., Manu Raju & Burgess Everett, *GOP lawmakers: Time to move on from Obamacare repeal*, POLITICO (June 25, 2015, 6:57 PM), <http://www.politico.com/story/2015/06/gop-lawmakers-time-to-move-on-from-obamacare-repeal-119439>.

is in the ACA, much of the public does not understand their options and fears the ACA's potential impact on their choice of care and how it will be paid for.¹¹

To date, most of the commentary and anxiety has centered over the ACA's access provisions and the mandate. Yet there is much more in the ACA that has been largely ignored.

Most believe the ACA was designed only to provide quality healthcare to all Americans through a pluralistic public and private system: private individual and small-employer-sponsored insurance, employer-provided insurance, and several government programs. The private or market component would be realized through centralized insurance marketplaces (known as exchanges), both for individuals and small employers (with less than 50 workers), and eventually through larger employers. The government component would be provided primarily through Medicaid and Medicare.

The ACA sets into motion a number of dynamics that will build upon a number of social and economic forces discussed in Section I and that will eventually realize its goal of universal coverage, but not in the way most anticipated it would do when the legislation was passed in 2010. Instead of a pluralistic public and private system, the final coverage vehicle will eventually become a single government program for everyone administered by private entities that only process enrollment, collect premiums and pay claims – very much like Medicare today. This will occur because the ACA will create an environment where both individual and institutional providers, employers, the general public and the states will become natural allies for a universal health care system much like Medicare. This surprising coalition will overwhelm the “free enterprise” advocates and force Congress to embrace a single payer “not-for-profit” system. The ACA and the emerging social and economic forces propelling it will produce this result in a very chaotic and untidy chain of events over the next decade.

In addition, the ACA will do much more than just expand access to coverage. Over time the ACA will transform not only how one pays for care, but how care is delivered. The ACA will transform today's medical professional paradigm from a fee-for-service entrepreneurial “sickness”

¹¹ See, e.g., KAISER HEALTH POLICY TRACKING POLL: THE PUBLIC'S VIEWS ON THE ACA, KAISER FAMILY FOUND. (2016), <http://kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=twoYear> (last viewed July 10, 2016).

model into a not-for-profit “wellness model” where the medical profession will regain much of the clinical autonomy it lost over the last 30 years. Many also believe that the ACA will result in better quality healthcare at lower cost largely because of concepts that permeate the ACA: value rather than volume purchasing and in particular comparative effectiveness research (CER).¹² This cost reduction may happen, but the experience in other countries makes this outcome indeterminate.

What is more certain is that the ACA will result in a more *efficient* health care system, where decisions in clinical evaluations will balance the incremental benefits of any treatment with its incremental cost and the efficacy of new interventions compared to existing ones. Such a comparison should result in better health outcomes and resource allocation than we have today, viewed from a population perspective. This increased efficiency may even result in a higher rather than a lower or a flatter cost curve relative to gross domestic product because of the transaction costs of moving the system towards “evidence-based medicine” and clinical decision-making that takes into account the marginal cost and benefit of any treatment. Once these initial costs are absorbed, the desired cost impact may be realized.

This Article is divided into four parts.

Section I will start with a brief description of the major social, economic, demographic, technological and political trends within which the ACA will be implemented and evolve over the next decade. This context is essential to understanding how the various ACA provisions will change or influence the direction of major components of the health care system and where things could go wrong. This context is also essential for making reasonable estimates of the political forces affected by the ACA and vice-versa and, therefore, what the U.S. healthcare system will look like in 2025.

Section II will describe how the ACA's provisions attempt to realize a pluralistic private/government access solution and how these efforts will set the stage for eliminating the private institutional sector from financial “risk taking,” diminish private insurers’ role in the delivery of care and hasten the exit of employers from their traditional role of sponsoring coverage.

One of the more significant unintended consequences of the ACA will be public dissatisfaction and jaundice regarding the private sector’s ability to finance and deliver healthcare better than the government. At the

¹² See *infra* Section III.

same time, the high cost for some of mandatory health insurance, rising deductibles and co-pays, and polarization of politics on the state and federal level will increase the public's distrust of government. Yet there are segments within the private sector where public opinion of the ACA is quite favorable and one of those areas involves clinicians delivering medical care. The ACA's structural changes will enhance rather than diminish the role and independence of clinicians regarding medical decisions.

Section III will examine several parts of the ACA that have not received much public attention. These include value-based purchasing, comparative effectiveness research, and several related ACA provisions which will dramatically change how new medical technology and new and existing practices are evaluated and delivered.

CER and these structural changes will reinforce the shift from today's entrepreneurial "for-profit" paradigm to a "not-for-profit" professional paradigm. That, in turn, will change how society and the medical profession view how much autonomy and regulation is proper regarding clinical medical decision-making and how providers should be compensated for such care.

The Article concludes with a prediction of the future evolution of the health care system under several possible scenarios based on different changes in control of the Congress and the White House, as well as other changes in the political landscape.

Interestingly enough, all of the scenarios, when viewed in the changing social and economic environment discussed in Section I, lead towards a common destination: a single government health care system for all that will resemble Medicare in structure and administration.

I. THE CULTURAL, ECONOMIC, POLITICAL, TECHNOLOGICAL AND DEMOGRAPHIC CONTEXT OF THE ACA

There are a number of societal changes underway that help explain the structure of the ACA, the challenges it must overcome and the importance of its dominating philosophies: value-based purchasing and comparative effectiveness research. These societal trends, while different, are very much interrelated and affect one another.

First and foremost, everyone, irrespective of his or her ideological or political bent or economic status, wants the employer out of the middle of the U.S. healthcare finance system. Market-oriented individuals would replace the employer sponsor with the individual worker via co-pays or a voucher-type system. The left would substitute government for the

employer. Employers, both large and small, just want out.¹³ Employers would still be involved via specific or general taxes or possibly some defined contribution type of benefit, but their present role as sponsors of health insurance coverage would be greatly diminished.

Another important influence is that the ACA favors network care control by the medical profession. The ACA does this in a number of ways, but primarily through its endorsement of a new type of network for Medicare called an “Accountable Healthcare Organization” or ACO. The ACO is a clinician-controlled network based on primary care physicians, electronic health records and collaboration between primary care physicians and ancillary and specialist providers participating in the network. The ACO mechanism seeks to make health care providers more accountable for healthcare savings and improved health outcomes through financial carrot and sticks. While originally limited to Medicare, the ACO concept is rapidly spreading throughout other government programs, such as Medicaid, and the private delivery system.¹⁴

Of equal importance is the fact that the ACA’s exchange regulations do not create a favorable environment for a for-profit (public company) insurer. For example, every exchange must have more than one insurer and one of these must be a “not-for-profit” entity.¹⁵ In addition, the ACA requires insurance participants to offer generous coverage (known as “essential health benefits”)¹⁶ with virtually no underwriting,¹⁷ meet

¹³ For some very preliminary estimates of the extent to which the availability of individual insurance on the exchanges encourages employers to refrain from sponsoring health coverage, see U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-12-768, PATIENT PROTECTION AND AFFORDABLE CARE ACT: ESTIMATE OF THE EFFECT ON THE PREVALENCE OF EMPLOYER-SPONSORED HEALTH COVERAGE (2012).

¹⁴ See Atul Gawande, *Overkill*, THE NEW YORKER (May 22, 2015) at 53; Tricia McGinnis, *A Unicorn Realized? Promising Medicaid ACO Programs Really Exist*, THE COMMONWEALTH FUND BLOG (March 11, 2015), <http://www.commonwealthfund.org/publications/blog/2015/mar/unicorn-realized-medicaid-acos> (“hundreds of ACOs [are] now sprouting up in an array of shapes and sizes in Medicare, Medicaid, and the commercial sector”).

¹⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10104(q), 124 Stat. 902 (2010) (codified at 42 U.S.C. § 18054(a)(1), (a)(3)).

¹⁶ *Id.* § 10104(b), 124 Stat. 896 (2010) (codified at 42 U.S.C. § 18022(a)-(b)). “Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use

required loss ratios (*i.e.*, returning between 80% and 85% of premiums collected in the form of insurance benefits),¹⁸ and operate subject to rate regulation¹⁹ and traditional insurance solvency regulation²⁰ that stresses adequate capital.

Competing dynamics inherent in a mixed free market operating under a public utility regulatory structure will force traditional insurance companies to either abstain from participating in many exchanges (many have already) or be selective about where they will participate (a form of underwriting).²¹ These dynamics will force these companies to move even more quickly than they are today towards the administration of premium and claims management rather than assuming risk. Already traditional insurance companies are desperately looking for new missions, such as “case management,” much like the March of Dimes looked for a new disease after tuberculosis was conquered.

disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.” *Essential Health Benefits*, HEALTHCARE.GOV (Sept. 9, 2015), <https://www.healthcare.gov/glossary/essential-health-benefits/> (2015). Minimum essential coverage does not include specialized coverage, such as coverage only for vision care or dental care or workers’ compensation or disability policies. Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. 244 (2010) (codified at 26 U.S.C. § 5000A(f)(3)); *see* 42 U.S.C. § 300gg-91(c).

¹⁷ Patient Protection and Affordable Care Act, § 1201(2)(A), (4), 124 Stat. 154–55 (2010) (codified at 42 U.S.C. §§ 300gg(a), 300gg-3(a)).

¹⁸ *See, e.g., id.* § 9016, 124 Stat. 872 (2010) (codified at 26 U.S.C. § 833(c)(5)).

¹⁹ *See, e.g.,* Ann Mills et al., *Truth and Consequences – Insurance Premium Rate Regulation and the ACA*, 363 NEW ENGLAND J. MED. 899, 899-900 (2010).

²⁰ *See, e.g.,* Patient Protection and Affordable Care Act, § 1322(c)(5), 124 Stat. 190 (2010) (codified at 42 U.S.C. § 18042(c)(5)).

²¹ *See, e.g.,* Reed Abelson & Agustin Armendariz, *In Colorado, Disparity in Health Plan Prices Underscores Ambitions, and Limits, of Affordable Care Act*, N.Y. TIMES, Jan. 19, 2015, http://www.nytimes.com/2015/01/20/business/in-year-2-of-affordable-care-act-premiums-diverge-widely.html?_r=0; U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-14-657, PATIENT PROTECTION AND AFFORDABLE CARE ACT: LARGEST ISSUERS OF HEALTH COVERAGE PARTICIPATED IN MOST EXCHANGES, AND NUMBER OF PLANS AVAILABLE VARIED (2014) (Insurers who pick and choose the geographic areas in which they choose to underwrite often do so to avoid areas with higher proportions of costly high-risk patients.).

One of the more important societal changes over the last 50 years is information technology (IT). IT has transformed virtually every aspect of our lives. Medicine is no exception. As hardware capabilities and processor capacity have grown geometrically, huge datasets have been created that can be updated in real time from many diverse government and private entities.

Just Google and peruse the *Dartmouth Atlas of Health Care*,²² which compiles data on virtually every aspect of medicine – not only with respect to practice variations, but also outcomes of alternative treatments. The *Dartmouth Atlas* is just one of many ongoing analyses taking advantage of this technology. Vast data sets can now be manipulated in an almost infinite number of ways, even down to the zip code level. This new capability will enable government and other healthcare entities to analyze new delivery and financing structures and clinical interventions in terms of outcomes and cost efficiency.

This IT capability makes CER not just a theory but a reality. The ACA also stresses substituting traditional medical charting with electronic records, which will enhance the coordination and continuity of care.²³ Last but not least, the new IT capabilities will facilitate the movement away from fee-for-service reimbursement to bundled payments,²⁴ which will enable enhanced coordination and continuity of care and network accountability.

Another critical dynamic is the significant distrust the public has for many public and private institutions, which influences their comfort

²² DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/> (last viewed June 28, 2015).

²³ See, e.g., Patient Protection and Affordable Care Act, §§ 1104(b)(2)(C), 3002(d), 124 Stat. 147, 365 (2010) (codified at 42 U.S.C. §§ 1320(i)(4)(B), 1395w-4(m)(7)).

²⁴ Under a bundled payment system, a payer such as Medicare makes one payment for services rendered by two or more providers during a one episode of care or a specified time period. See, e.g., *Bundled Payments*, AMERICAN MEDICAL ASS'N, <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/bundled-payments.page> (last viewed July 6, 2015). Bundled payments essentially place the risk of the cost of medical services for a particular episode on healthcare providers. See Suzanne Delbanco, *The Payment Reform Landscape: Bundled Payment*, HEALTH AFFAIRS BLOG (July 2, 2014), <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>.

level regarding with whom, if anyone, they will share their decision making power – especially on a sensitive subject like healthcare. Government is one of the least trusted, while the medical profession is the most trusted. This disparity is clearly reflected in the ACA's provisions regarding the implementation of CER process, with its focus on voluntary adoption of best treatment options, transparency and related measures.²⁵

The ACA's task is a formidable one, fundamentally changing over one-seventh of the U.S. economy.²⁶ Many things will go wrong, especially during the early stages, which will only enhance the public's disenchantment with the private sector's ability and to a lesser degree the government's ability to solve the problem of access and affordability.

Another important trend relates to the median wage in the United States. For a variety of reasons, the median wage has remained relatively stagnant since the 1970s²⁷ and wealth inequality has increased dramatically over that same period.²⁸ At the same time, the cost of medical care grew faster than GDP through 2009 in the United States.²⁹ This combination of

²⁵ See, e.g., Patient Protection and Affordable Care Act, § 1552, 124 Stat. 258 (2010) (codified at 42 U.S.C. § 1396a(a)(1)(A)(i)(VIII)).

²⁶ See CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURE DATA: HISTORICAL, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last viewed June 28, 2015) (In 2013, healthcare expenditures accounted for 17.4% of the U.S. gross domestic product.).

²⁷ See, e.g., Drew DeSilver, *For Most Workers, Real Wages Have Barely Budgeted for Decades*, PEW RESEARCH CENTER (Oct. 9, 2014), <http://www.pewresearch.org/fact-tank/2014/10/09/for-most-workers-real-wages-have-barely-budgeted-for-decades/>.

²⁸ See, e.g., *Nine Charts About Wealth Inequality in the United States*, URBAN INST. (Feb. 2009), <http://datatools.urban.org/Features/wealth-inequality-charts/>.

²⁹ See Veronique de Rugy, *U.S. Healthcare Spending More Than Twice the Average for Development Countries*, MERCATUS CENTER—GEORGE MASON UNIVERSITY (Sept. 17, 2013), <http://mercatus.org/publication/us-health-care-spending-more-twice-average-developed-countries>. From 2010 through 2013, healthcare expenditures in the U.S. grew at approximately the same rate as GDP. CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURES 2013 HIGHLIGHTS, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>. In 2014, healthcare expenditures once again surpassed GDP. CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURES 2014 HIGHLIGHTS, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics->

forces increased the ranks of the uninsured. The ACA's expansion of Medicaid to 133% of the federal poverty level³⁰ and its use of tax credits and subsidies for coverage purchased through the exchanges³¹ attempt to ameliorate the impact of the growing unaffordable cost of health care. The Supreme Court's 2015 decision upholding the payment of subsidies in states with federal exchanges³² removed the legal doubt surrounding the continuation of those subsidies in all fifty states.

Then there is our aging population,³³ which will only bolster the number of Medicare recipients over the next several decades. Entitlement reform, while inevitable, may change eligibility and the generosity of benefits, but it will not alter the basic structure of a government-run safety net for the elderly.

Medicare combined with other government programs paid 43% of the total expenditures on healthcare in 2013.³⁴ Even with entitlement reform, government monies will dominate the healthcare system. Accordingly, virtually all providers, both private and institutional, depend now and will increasingly depend upon government revenues. The entity that controls the purse strings is also in a position to impose conditions for receipt of these monies and influence the contours of the system.

Decisions regarding government programs and in particular Medicare will influence both the private and government health care system. For example, in 1980, Medicare changed hospital reimbursement from fee-for-service to a prospective payment system.³⁵ If a hospital

Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf; Paul Handley, *US economic growth in 2014 fastest in four years*, AFP (Jan. 30, 2015), <https://www.yahoo.com/news/us-economy-grew-2-6-q4-slower-expected-135115848.html?ref=gs>.

³⁰ See, e.g., Patient Protection and Affordable Care Act, § 2001(a)(1), 124 Stat. 271 (2010) (codified at 42 U.S.C. § 1396a(a)(1)(A)(i)(VIII)).

³¹ See, e.g., *id.* §§ 1401-1421, 124 Stat. 213-242 (2010).

³² *King v. Burwell*, No. 14-114, slip op. at 5 (U.S. Jul. 27, 2015).

³³ See *Aging Statistics*, ADMINISTRATION ON AGING, http://www.aoa.acl.gov/Aging_Statistics/index.aspx. (last viewed June 28, 2015).

³⁴ See CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURE DATA: NHE FACT SHEET, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> (last viewed June 28, 2015) (computations by editor).

³⁵ See, e.g., RAND CORP., EFFECTS OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF HOSPITAL CARE,

received just one penny of Medicare funds, it was required to charge that rate to all other Medicare beneficiaries. Shortly thereafter, private payers began to mimic Medicare's prospective payment approach in one form or another.³⁶ The same occurred with respect to the reimbursement of physicians. Today, under the ACA, Medicare hospitals and ACO providers must also participate in a “shared savings” reimbursement system, which is accompanied by many practice and quality standards.³⁷

To summarize, the Affordable Care Act was unveiled amidst an environment where household wages were stagnant, employers wanted to drop health insurance benefits for their workers, the government sought lower health costs and better health outcomes, insurers were already contemplating an exit from underwriting, information technology made it possible to pinpoint more effective treatments, and people placed their trust in their doctors, not in insurers or the government. For the reasons that Section II describes in further detail, the design of the ACA interacts with these dynamics to create an unstable situation where employers, insurers, and the public will increasingly reject the ACA's hybrid private-public model in favor of a single-payer, government system of health insurance coverage.

II. UNINTENDED CONSEQUENCES OF THE ACA'S “BALKANIZED” APPROACH TO THE UNINSURED: DIRECT GOVERNMENT COVERAGE AND ACCESS TO COVERAGE VIA THE PRIVATE SECTOR AND MANDATES

This section describes how the ACA attempts to: 1) extend coverage to the uninsured; 2) preserve a central role for private sector “for-profit” risk-takers, a.k.a. insurance companies; and 3) maintain and even expand employers' historic role as the primary sponsors of health plan benefits. This section will argue that the ACA will only have partial success regarding access to affordable care and will have just the opposite

http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB4519-1.pdf.

³⁶ See Cherie Phillips, *Private Health Insurance*, CASE WESTERN RESERVE UNIVERSITY, http://www.cwru.edu/med/epidbio/mphp439/Private_Insurance.htm (last viewed June 28, 2015).

³⁷ See Patient Protection and Affordable Care Act, § 3022, 124 Stat. 395 (2010) (codified at 42 U.S.C. § 1395jii).

of its intended effect regarding private sector risk-takers and employer participation.

The ACA takes several different approaches to getting health insurance coverage to the uninsured. One approach is to expand Medicaid to more people³⁸ (though the states have to concur in this expansion as a result of a 2012 Supreme Court decision).³⁹ Another is to require all insurance plans -- both insured and self-insured -- to contain certain provisions, such as guaranteed issue, limits on pre-existing conditions, preventive exams, coverage for dependents up to age 26, and no lifetime dollar limits.⁴⁰ Still another is a vehicle for individuals and small groups to purchase coverage in a government-regulated marketplace called an insurance exchange⁴¹ -- this is a guaranteed *access* approach to insurance rather than *direct government* insurance.

Access to coverage is not the same as providing direct or automatic coverage. Instead, individuals and small employers have to be eligible for the coverage and pay for it. When one has access rather than direct coverage, individuals and groups purchase coverage through private for-profit and not-for-profit insurance companies. Individuals and small employers are encouraged to exercise this right to access through penalties for not having minimum coverage⁴² and means testing what one has to pay for coverage through tax credits and subsidies.⁴³

These initiatives will not be successful or at a minimum will fall far short of their intended objectives. In fact, this Article argues that these well-intentioned initiatives will have two unintended opposite effects: 1) the development of a broad public consensus that private “for-profit” enterprises cannot play a constructive role in the financing and delivery of affordable quality healthcare; and 2) facilitating and incentivizing

³⁸ See, e.g., Patient Protection and Affordable Care Act, § 2001(a)(1), 124 Stat. 271 (2010) (codified at 42 U.S.C. § 1396a(a)(1)(A)(i)(VIII)).

³⁹ Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012).

⁴⁰ Patient Protection and Affordable Care Act, §§ 1001(5), 1201(2)(A), (4), 10103(a), 10104(b), 124 Stat. 131-32, 154-56, 892, 896 (2010) (codified at 42 U.S.C. §§ 300gg(a), 300gg-1(a), 300gg-2, 300gg-3, 300gg-4, 300gg-11, 300gg-13, 300gg-14, 18022(a)-(b)).

⁴¹ *Id.* § 1311(b)(1), 124 Stat. 173 (2010) (codified at 42 U.S.C. § 18031(b)(1) (2010)); see also King v. Burwell, No. 14-114, slip op. at 5 (U.S. Jul. 27, 2015).

⁴² Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. 244 (2010) (codified at 26 U.S.C. § 5000A).

⁴³ See *id.* §§ 1401-21, 124 Stat. 213-42 (2010).

employers to reduce rather than expand or maintain their operative role in the present system.

Before summarizing the details of the ACA's access components and the challenges the ACA faces in realizing its access objectives, it is useful to examine the demographics of the uninsured population. The demographics explain why the ACA has so many different thresholds regarding and rules for eligibility, mandates, and means-tested ACA tax incentives.

A. THE DEMOGRAPHICS OF THE UNINSURED AND THE DYSFUNCTIONAL “INDIVIDUAL AND SMALL GROUP” PRIVATE INSURANCE MARKET

As of 2010 (when the ACA was enacted), the U.S. had 49.9 million uninsured individuals, comprising 18.4% of the non-elderly population.⁴⁴ Numerous uninsured individuals that year did not have coverage because they were either not working or their employers did not offer coverage.⁴⁵ In addition, many had low motivation to get coverage either because they were young and viewed themselves as invulnerable or coverage was unaffordable in the individual market. Even in the employer-sponsored market, employer and employee contributions were perceived to be too high.⁴⁶ Reduced to essentials, for those individuals, the cost of coverage

⁴⁴ U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE: 2010 - *Tables & Figures*, fig. 7, tbl. 8, <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/tables.html>; DEPARTMENT OF HEALTH AND HUMAN SERVS., OVERVIEW OF THE UNINSURED IN THE UNITED STATES: A SUMMARY OF THE 2011 CURRENT POPULATION SURVEY (Sept. 2011), <http://aspe.hhs.gov/health/reports/2011/cpshealthins2011/ib.shtml> (reporting that the age ranges of the uninsured that year were as follows: 9.8% were below the age of 18; 29.7% were between 19 and 25 years of age; 28.4% were between 25 and 34 years; and 38.1% were between 35 and 64 years of age. In terms of income, 58.7% earned less than \$50,000 a year and 15.4% earned between \$50,000 and \$74,999 a year.).

⁴⁵ DEPARTMENT OF HEALTH AND HUMAN SERVS., OVERVIEW OF THE UNINSURED IN THE UNITED STATES: A SUMMARY OF THE 2011 CURRENT POPULATION SURVEY (Sept. 2011), <http://aspe.hhs.gov/health/reports/2011/cpshealthins2011/ib.shtml>.

⁴⁶ *See Recent Premium Increases Imposed by Insurers Averaged 20% for People Who Buy Their Own Health Insurance, Kaiser Survey Finds*, KAISER FAMILY FOUND. (June 21, 2010), <http://kff.org/private-insurance/press-release/recent-premium-increases-imposed-by-insurers-averaged-20-for-people->

exceeded the perceived value of or need for health insurance coverage relative to other uses of one's money, particularly for people squeezed by flat wages and job instability.

For years the individual and small group markets (defined as employers with less than 50 full-time employees) had been dysfunctional. The pools in this market were spread among many blocks of individuals and small employers. As a result the pools available for distributing risk were much smaller than those available to larger companies or associations to aggregate risk.⁴⁷ In addition, the individuals in these markets were not as healthy as those in the larger group market because of poverty and related reasons.⁴⁸

Affordability was exacerbated in the individual and small group markets because of the small pools, not only because small pools inhibit efficient risk distribution but also because of the increased transaction costs associated with the robust underwriting necessary to minimize adverse selection in an unhealthy population. Affordability was also hampered by the inability of insurance companies to realize economies of scale when setting up and administering many individual and small group policies.⁴⁹

In addition, individuals and employers pre-ACA were not required to buy or provide coverage. Those who sought coverage were often turned down to reduce adverse selection.⁵⁰ Insurers excluded coverage of pre-

who-buy-their-own-health-insurance-kaiser-survey-finds/; see also L. Levitt, G. Claxton & A. Damico, *Measuring the Affordability of Employer Health Coverage*, KAISER FAMILY FOUND. (Aug. 24, 2011), <http://www.kff.org/health-costs/perspective/measuring-the-affordability-of-employer-health-coverage/>; DEPARTMENT OF HEALTH AND HUMAN SERVS., OVERVIEW OF THE UNINSURED IN THE UNITED STATES: A SUMMARY OF THE 2011 CURRENT POPULATION SURVEY (Sept. 2011), <http://aspe.hhs.gov/health/reports/2011/cpshealthins2011/ib.shtml>.

⁴⁷ See Lester Feder & Ellen-Marie Whelan, *An Unhealthy Individual Health Insurance Market*, CTR. FOR AMERICAN PROGRESS (Dec. 23, 2008), <https://www.americanprogress.org/issues/healthcare/news/2008/12/23/5259/an-unhealthy-individual-health-insurance-market/>.

⁴⁸ See Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 HEALTH AFFAIRS 1714, 1716 (2010).

⁴⁹ See Bernadette Fernandez, *Health Insurance: A Primer*, in HEALTH CARE CRISIS IN AMERICA 84, 90 (Janet B. Prince, ed., 2005).

⁵⁰ See, e.g., Melissa Majerol et al., *The Uninsured: A Primer – Key Facts About Health Insurance and the Uninsured in America*, KAISER FAMILY FOUND. (Jan. 13, 2015), http://kff.org/report-section/the-uninsured-a-primer-what-was-happening-to-insurance-coverage-leading-up-to-the-aca/#endnote_link_136859-8.

existing conditions for those who did qualify for coverage in the individual market to further cut down on adverse selection.⁵¹ Pre-ACA, insurance companies could often also decide what to charge.⁵² “Cherry picking” via the underwriting process and fear of adverse selection from an abnormally poor health population exacerbated the distribution process and incentivized insurance companies to make very conservative actuarial assumptions.⁵³

As a result of all of these factors, the rates for coverage in the individual and small group markets were generally higher than they were in a normal functioning insurance market and the availability of coverage varied greatly between insurance companies.⁵⁴

Much of the ACA’s uninsured initiatives attempt to rationalize the individual and small group market through a number of restrictions on underwriting, the regulation of insurance rates, and a concept that we will explore later called “shared responsibility.”

B. THE ACA’S PRIMARY UNINSURED COMPONENTS: THE INSURANCE EXCHANGE, THE MANDATE AND MEDICAID

The part of the ACA that has received the most coverage and visibility to date is the exchange/mandate concept, which is an effort to ameliorate adverse selection and to bring more competition into the small group/individual market and eventually the entire employer-sponsored market. It is also an effort to make private insurance companies an integral part of the uninsured solution.

Initiatives to make the private health insurance market more competitive have been around in various forms for some time. Previous labels include the “managed competition” that surfaced in the 1980s and was similar to the health insurance purchasing cooperatives in the Clinton Administration plan in the 1990s.

The exchange/mandate concept embraced by the ACA is the latest example of these initiatives. Some believe that competition in healthcare finance via exchanges and mandates coupled with tax subsidies will enable consumers to choose the best coverage for themselves and assure better

⁵¹ See Feder & Whelan, *supra* note 47.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ See, e.g., *id.*; see also Majerol et al., *supra* note 50; Newhouse, *supra* note 48, at 1716.

service than direct government coverage. Many also embrace the exchange concept because of its appeal to the right or middle right of the political spectrum. They believe that private insurers in a free market will result in a more efficient health care system than a system run by the government. Not surprisingly, the mandate/exchange concept was pushed forward in the 1980s by the Heritage Foundation -- a conservative think tank -- as being more in line with our economic market system.⁵⁵ Ironically, it was the Heritage Foundation that decided in 2011 to argue that the mandate was unconstitutional.⁵⁶

1. The Insurance Exchange and Essential Health Benefits

During the debates leading up to the passage of the ACA, many strongly believed that Americans should have the choice of a public health insurance option operating alongside private plans. They believed that having a public option would give them a better range of choices, make the health care market more competitive, and “keep insurance companies honest.” However, the public health insurance option was ultimately dropped from the reform legislation; the insurance sold on the health insurance exchanges in the United States will, therefore, now be exclusively from the private insurers.⁵⁷ Off of the exchanges, Medicare and Medicaid will continue to serve the elderly and the poor. Thus, the ACA rejected a single-payer, social insurance model in favor of a hybrid approach based on a combination of private *and* government financing and guaranteed access to health coverage.

Under this hybrid approach, the ACA requires each state (and in the absence of states doing so, the federal government) to establish an “insurance exchange” -- that is, a government-run, easily accessible, and consumer-friendly market bazaar, where private insurance companies certified by the U.S. Department of Health and Human Services offer

⁵⁵ See Avik Roy, *How the Heritage Foundation, a Conservative Think Tank, Promoted the Individual Mandate*, FORBES (Oct. 20, 2011, 8:26 AM), <http://www.forbes.com/sites/apothecary/2011/10/20/how-a-conservative-think-tank-invented-the-individual-mandate>.

⁵⁶ See Robert E. Moffitt, *Individual Mandate Unconstitutional, Unenforceable*, HERITAGE FOUNDATION (March 23, 2011), <http://www.heritage.org/research/commentary/2011/03/individual-mandate-unconstitutional-unenforceable>.

⁵⁷ See Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFAIRS 1117, 1117 (2010).

plans.⁵⁸ Individuals can buy health insurance on the exchange and so can small employers, which are entitled to a tax credit of up to 50% of the exchange premium depending on the number of employees and the average salary.⁵⁹ To discourage oligopoly pricing, each exchange must have two or more insurers and at least one must be a “not-for-profit” entity.⁶⁰ As this latter provision suggests, one of the main purposes of the exchanges is to increase price competition among insurers. Another is to assemble larger pools in order to reduce adverse selection and promote economies of scale.

Another way the ACA seeks to increase price competition and coverage is through standardization of benefits. The certified insurance plans participating in an exchange must offer a number of standard health insurance policies with varying co-pays and deductibles and prices that reflect the cost and overhead of providing these coverages.⁶¹ The ACA labels the standard content of each policy “essential health benefits.”⁶² The ACA’s requirement for standard coverages will facilitate price and service comparisons and with it, ideally, price competition.⁶³ That requirement

⁵⁸ Patient Protection and Affordable Care Act, § 1311(b)(1), 124 Stat. 173 (2010) (codified at 42 U.S.C. § 18031(b)(1)); *see also* King v. Burwell, No. 14-114, slip op. at 5 (U.S. Jul. 27, 2015).

⁵⁹ Patient Protection and Affordable Care Act, §§ 1311(b), (d)(2)(A), 1421(a), 124 Stat. 173, 176, 237 (2010) (codified at 42 U.S.C. §§ 18031(b), (d)(2)(A) and 26 U.S.C. § 45R). For tax years 2010 through 2013, the maximum credit was 35% for small business employers and 25% for small tax-exempt employers such as charities. An enhanced version of the credit took effect on January 1, 2014. In general, on January 1, 2014, the rate increased to 50% and 35%, respectively. *See Small Business Health Care Tax Credit Questions and Answers: Calculating the Credit*, INTERNAL REVENUE SERV. (August 11, 2015), <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Calculating-the-Credit>.

⁶⁰ Patient Protection and Affordable Care Act, § 10104(q), 124 Stat. 902 (2010) (codified at 42 U.S.C. § 18054(a)(1), (a)(3)).

⁶¹ *Id.* §§ 1301(a)(1), 1302, 124 Stat. 162-63 (2010) (codified at 42 U.S.C. §§ 18021(a)(1), 18022).

⁶² *Id.* § 10104(b), 124 Stat. 896 (2010) (codified at 42 U.S.C. § 18022(a)-(b)).

⁶³ To assist in informed comparison-shopping, each exchange must have consumer advisers (either in the form of “navigators,” “in-person assistance personnel,” or “certified application counselors”) to help consumers understand the application process, their eligibility to buy through the exchange, any availability of Medicaid, and their eligibility for tax credits and subsidies. *Id.* § 1311(i); *see also In-Person Assistance in the Health Insurance Marketplaces*, THE CTR. FOR CONSUMER INFO. & INSURANCE OVERSIGHT, <https://www.cms.gov/CCIIO/Programs-and->

will also have the important effect of expanding available coverage (both in the individual market and in employer-sponsored plans).

The ACA also seeks to ensure universal coverage by guaranteeing access, by eliminating exclusions to coverage, and by making coverage affordable. Thus, in order to participate in the exchange, an insurance company plan must be certified as meeting the criteria for a qualified health plan established by the Department of Health and Human Services,⁶⁴ namely:

- o *Guaranteed issue* -- Insurers are not permitted to refuse coverage for any individual or group based on health status and, in particular, pre-existing conditions.⁶⁵
- o *Restrictions on rescission* -- This requirement mirrors the guaranteed issue requirement in that an insurer cannot cancel and must renew coverage irrespective of health status or the experience of the group and in particular pre-existing conditions.⁶⁶
- o *Limits on price variation by class* -- Plans must offer a form of “community rating,” that is, the same rate irrespective of one's health status, age, etc., with two exceptions: use of tobacco and a limited price adjustment for specified age bands. There may be one community rate for individuals and one for families.⁶⁷
- o *Comparable tiers of plans* -- Insurance companies must offer four different versions of the standard coverages differentiated primarily by the dollar level of co-pays and deductibles. These coverages are

Initiatives/Health-Insurance-Marketplaces/assistance.html; Gary Cohen, *Guidance on Certified Application Counselor Program for Federally-Facilitated Marketplace Including State Partnership Marketplaces*, DEP'T OF HEALTH AND HUMAN SERVS. (July 12, 2013), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CAC-guidance-7-12-2013.pdf>.

⁶⁴ Patient Protection and Affordable Care Act, §§ 1301, 1311(c), 124 Stat. 162, 174 (2010) (codified at 42 U.S.C. §§ 18021, 18031(c)).

⁶⁵ *Id.* §§ 1101, 1201(2)(A), (4), 124 Stat. 141, 154-56 (2010) (codified at 42 U.S.C. §§ 18001, 300gg-1, 300gg-3, 300gg-4).

⁶⁶ *Id.* § 1201(4), 124 Stat. 156 (2010) (codified at 42 U.S.C. § 300gg-2).

⁶⁷ *Id.* §§ 1101, 1201(4), 124 Stat. 141, 155 (2010) (codified at 42 U.S.C. § 300gg).

labeled Bronze, Silver, Gold and Platinum Plans.⁶⁸ Certified insurers must also offer a catastrophic coverage for individuals under age 30 or with hardship exemptions with a deductible equal to the high deductible plans linked to health savings accounts.⁶⁹ For 2016, the limits on deductibles under catastrophic coverage plans were \$6,850 per year for individuals.⁷⁰

- o *No lifetime limits* -- Insurers are not permitted to engage in the traditional practice of setting an annual or lifetime dollar limits.⁷¹
- o *Availability of subsidies and tax credits* -- Insurers must honor subsidies and credits for those whose annual income is between 138% and 400% of the federal poverty level to help pay for the purchase of insurance coverage on an exchange.⁷²

These provisions are intended to produce universal coverage in three important ways. The guaranteed issue requirement, the limitations on rescission, and the elimination of lifetime limits ensure that individuals will not be denied coverage due to health status or dollar caps.⁷³ The provisions on community rating and tiered plans are both designed to make the menu options on the exchanges more affordable for certain customers. Finally, Congress enacted the subsidies and tax credits because many otherwise would be priced out of health coverage.⁷⁴

Many of these same provisions, however, shift significant and some say unmanageable risks onto insurers. Under the ACA, insurers are deprived of four techniques that they previously used to manage risks and discourage adverse selection: denial of coverage, coverage exclusions, lifetime caps, and individual risk-adjusted pricing. In addition, private insurers on the exchanges face added and unwanted competition, both from

⁶⁸ *Id.* § 1302(d), 124 Stat. 167 (2010) (codified at 42 U.S.C. § 18022(d)).

⁶⁹ *Id.* § 1302(e), 124 Stat. 168 (2010) (codified at 42 U.S.C. § 18022(e)).

⁷⁰ How to pick a health insurance plan, HealthCare.Gov, <https://www.healthcare.gov/choose-a-plan/plans-categories/> (last viewed July 10, 2016).

⁷¹ Patient Protection and Affordable Care Act, § 1001(5), 124 Stat. 131 (2010) (codified at 42 U.S.C. § 300gg-11).

⁷² *Id.* § 1401(a), 124 Stat. 215 (2010) (codified at 26 U.S.C. § 36(c)).

⁷³ *See* King v. Burwell, 135 S. Ct. 2480 (2015).

⁷⁴ *Id.*

one another and from the not-for-profit insurers that the ACA requires and in fact encourages through regulation, grants and loans.⁷⁵ These not-for-profit initiatives focus on the very healthy populations that private insurers are trying to attract.

The ACA also subjects insurers to added rate regulation to help keep policies affordable. In addition to federal review, the states will have the ability to ensure that the policies conform to federal standards and that rates are supported by verifiable data and subject to the medical loss ratios (MLR).⁷⁶ Under the MLR requirement, insurers (both within and outside the exchange) must provide health benefits equaling 80% of the premium dollar for individual coverage and 85% for group coverage. States will review insurance company and self-insured data to verify that MLR standards have been met and to the degree the benefit requirement has not been met, the difference will be rebated to the individual or employer.⁷⁷ States are permitted to disapprove or even set lower health insurance rates.⁷⁸ Special review is provided both at the federal and state level for rate

⁷⁵ The law requires the Comptroller General to establish a 15-member board to make recommendations to the Secretary of Health and Human Services with regard to the award of grants and loans to these not-for-profit plans, known as Consumer Operated and Oriented Plans (CO-OPs). See Patient Protection and Affordable Care Act, § 1322, 124 Stat. 187 (2010) (codified at 42 U.S.C. § 18042). The board appointments were made in 2010. The Center for Consumer Information and Insurance Oversight (CCIIO) within the Department of Health and Human Services works with the advisory board to assist and advise the Secretary and Congress on HHS's strategy to foster the creation of qualified nonprofit health insurance issuers. Specifically, the advisory board provides advice regarding the awarding of grants and loans related to the CO-OP program. In these matters, the Committee shall consult with all components of the Department, other federal entities and non-federal organizations, as appropriate. It will also examine relevant data sources to assess the grant and loan award strategy to provide recommendations to CCIIO. *See id.*

⁷⁶ *Id.* §§ 1331(b), 9016(a), 124 Stat. 200, 872 (2010) (codified at 42 U.S.C. § 18051 and 26 U.S.C. § 833).

⁷⁷ *Id.* § 1001(5), 124 Stat. 137 (2010) (codified at 42 U.S.C. § 300gg-18(b)); *see also* Department of Health and Human Servs., *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule*, 75 Fed. Reg. 74864, 74865-66 (Dec. 1, 2010).

⁷⁸ *See, e.g.,* Mills et al., *supra* note 19. *See generally* John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88 TEMPLE L. REV. 411 (2016) (arguing that the ACA's expansion of the health insurance rate review process could be a more

increases exceeding 10%.⁷⁹ States are also required to make sure that qualified health plans meet state solvency standards,⁸⁰ such as adequate reserves, quality reserves, and prudent management practices applicable to all insurance companies operating the state.

These requirements all collide with the fact that typically, health insurance providers operate with thin margins.⁸¹ The ACA's MLR and rate review provisions are likely to cut further into those margins and make health insurance carriers more hesitant to continue underwriting risk.

The ACA's new crop of taxes and fees for insurers will only add to that reluctance. Under the ACA, the federal government, state governments, insurers, employers, and individuals have a "shared responsibility to reform and improve the availability, quality and affordability of health insurance coverage in the United States."⁸² This "shared responsibility" is achieved in part through taxes and fees on insurers that not only participate in the exchanges but also those that only provide health coverage administration outside the exchange.

The fees start with the exchange itself. The ACA provides that a state with an exchange must "ensure that [its] Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."⁸³

effective cost containment tool if updated to address contemporary health insurance market failures).

⁷⁹ 45 C.F.R. § 154.200.

⁸⁰ See, e.g., Patient Protection and Affordable Care Act, § 1322(c)(5), 124 Stat. 190 (2010) (codified at 42 U.S.C. § 18042(c)(5)).

⁸¹ See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS & THE CENTER FOR INSURANCE POLICY AND RESEARCH, 2014 HEALTH INSURANCE INDUSTRY ANALYSIS REPORT, at 1 (2014), http://www.naic.org/documents/topic_insurance_industry_snapshots_2014_health_ind_report.pdf (last viewed July 1, 2015); see also Avik Roy, *Private Insurer Profits? \$13 Billion. Medicare Fraud? \$48 Billion. Health Reform? Priceless.*, FORBES, March 4, 2011, <http://www.forbes.com/sites/aroy/2011/03/04/private-insurer-profits-13-billion-medicare-fraud-48-billion-health-reform-priceless/>.

⁸² Internal Revenue Serv., *Questions and Answers on the Individual Shared Responsibility Provision, Question 1*, <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision> (last viewed June 29, 2015).

⁸³ Patient Protection and Affordable Care Act, § 1311(d)(5)(A), 124 Stat. 178 (2010) (codified at 42 U.S.C. § 18031(d)(5)(A)).

There are still other fees or taxes. For example, the ACA imposes a Health Insurance Providers Fee on each health insurance company writing group coverage starting in 2014 equal to \$8 billion allocated among each of the companies based on their national market share. This fee will increase each year to \$14.3 billion by 2018 and will remain in place thereafter adjusted annually for inflation.⁸⁴

Another tax is the so-called “Cadillac” tax. Here, health insurers (and self-funded plans) must pay a 40% tax that applies to workplace plans on any part of monthly premiums paid by employers that exceed defined thresholds for single and family coverage.⁸⁵ Many observers believe the “Cadillac tax” will provide an incentive to health plans to control the cost of health insurance and for individuals and employers to purchase less expensive plans. In 2018, the thresholds will be \$10,200 for single coverage and \$27,500 for family coverage.⁸⁶

These taxes help fund the premium tax subsidies and credits under the ACA. The taxes are also designed to encourage employers to reduce the amount of coverage for their employees, which will increase tax revenues because of the present characterization of healthcare benefits as not being taxable income. This exemption from the income tax laws was a historical accident and has been questioned over the years, but repeal of the exemption never got anywhere because it was politically unpopular. In recent years, however, repeal has been seriously reconsidered since reducing the federal deficit has become a top priority.

In sum, this combination of severe underwriting restrictions, community rating, minimum loss ratios, rate review, required expanded benefits, mandatory competition from not-for-profit insurers, and taxes, some of which are designed in part to reduce employee healthcare benefits sponsored by the employer (even if an employer self-insures and uses a

⁸⁴ *Id.* § 9010, 124 Stat. 865 (2010) (codified at 26 U.S.C. § 4001 note prec.); see Internal Revenue Serv., *Affordable Care Act Provision 9010 --- Health Insurance Providers Fee*, <http://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010> (last viewed June 29, 2015).

⁸⁵ Patient Protection and Affordable Care Act, § 9001(a), 124 Stat. 847 (2010) (codified at 26 U.S.C. § 49801). The ACA mandates still other taxes on pharmaceuticals, medical device manufacturers, and elective cosmetic medical procedures. *Id.* §§ 9008, 9009, 9017, 124 Stat. 859, 862, 872 (2010) (codified at 26 U.S.C. §§ 4001 note prec., 5000B).

⁸⁶ Internal Revenue Serv., *Section 49801 — Excise Tax on High Cost Employer-Sponsored Health Coverage*, Notice 2015-16, at 3 (2015).

health insurance company only as an administrator), create the perfect storm for a business model based on thin margins and high volume. It is also a business model that runs a high risk of large losses and the unpredictability of such losses. Due to these design features of the ACA, insurers and employers who self-insure will militate more strongly than ever to exit the provision of health coverage.

2. Shared Responsibility for Individuals and Employers: The Mandate

The ACA seeks to cure the small pools and adverse selection that formerly plagued the individual market through a triad of mechanisms. Its guaranteed issue, no-lifetime-cap, and essential minimum benefit provisions give access to universal coverage. The subsidies and tax credits help ensure that access is affordable. Finally, the mandate imposes fines on individuals and large employers who respectively fail to sign up for, or provide their workers with, required coverage.⁸⁷

The individual and employer mandate is a “pay or play” mandate. While the ACA allows individuals to go without coverage and employers not to provide coverage, the ACA imposes a penalty on individuals who choose not to buy minimum essential coverage⁸⁸ and on employers that refuse to provide that coverage.⁸⁹

Acceptable coverage that complies with this mandate includes:⁹⁰

- Employer-sponsored coverage (including COBRA coverage and retiree coverage)
- Coverage purchased in the individual market
- Medicare coverage (including Medicare Advantage)
- Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans' health coverage
- TRICARE (coverage for members of the military and veterans and their dependents)

⁸⁷ See *King v. Burwell*, 135 S. Ct. 2480 (2015).

⁸⁸ Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. 244 (2010) (codified at 26 U.S.C. § 5000A).

⁸⁹ *Id.* § 1513(a), 124 Stat. 253 (2010) (codified at 26 U.S.C. § 4980H).

⁹⁰ *Id.* § 1501(b), 124 Stat. 244 (2010) (codified at 26 U.S.C. § 5000A(f)).

In 2014, the individual “shared responsibility” penalty was \$95 per person (or \$47.50 per child, capped at \$285 per family or 1% of the family’s yearly income, whichever was greater).⁹¹ The penalty increased each year as follows:

2015: \$325 per adult and \$162.50 per child under 18 (capped at \$975 per family or 2% of the family’s income, whichever was greater).⁹²

2016: \$750 per adult and \$347 per child (capped at \$2000 per family or 2.5% of the family’s income, whichever was greater).⁹³

2017: the same as 2016 adjusted for inflation.⁹⁴ Accordingly, the penalty will increase each year, but will be capped at the bronze level exchange premium for the individual or family.⁹⁵

Individuals subject to this mandate include children, the elderly, citizens living abroad and documented foreign nationals living in this country.⁹⁶ Although the ACA provides for qualified plans and exchanges to have mechanisms to deal with unanticipated risks,⁹⁷ the nature of the ACA mandate creates fertile ground for adverse selection. The key question is whether the ACA’s penalties provide enough incentive for

⁹¹ *Id.* (codified at 26 U.S.C. § 5000A(c)(3)(B)); see *The fee you pay if you don't have health coverage*, HEALTHCARE.GOV, <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/> (last viewed June 30, 2015).

⁹² Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. 244 (2010) (codified at 26 U.S.C. § 5000A(c)(3)(B)); see *The fee you pay if you don't have health coverage*, HEALTHCARE.GOV, <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/> (last viewed July 11, 2015).

⁹³ Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. 244 (2010) (codified at 26 U.S.C. § 5000A(c)(3)(A)).

⁹⁴ *Id.* (codified at 26 U.S.C. § 5000A(c)(3)(D)).

⁹⁵ *Id.* (codified at 26 U.S.C. § 5000A(e)(1)(B)).

⁹⁶ *Id.* (codified at 26 U.S.C. § 5000A(d)).

⁹⁷ *Id.* §§ 1341-1343, 124 Stat. 208-213 (2010) (codified at 42 U.S.C. §§ 18061-18063); see also *Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk*, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-447 (2015).

people to buy through the exchange or elsewhere. The exchange rates for New York for 2014, which many characterized as being much lower than the non-exchange private market, were revealing. The average New York exchange rate for a single individual on a silver plan was \$483 annually before federal subsidies. That same average rate was \$966 for a married couple and \$1377 for family coverage.⁹⁸ That meant that the average premium to buy health coverage through the New York exchange was about 5 times greater than the penalty during the first year.

The ACA also specifies “pay or play” penalties for large employers that do not provide fully insured or self-insurance coverage for their “full-time employees.”⁹⁹ This sharply changes the previous state of affairs where private employers could decline to provide health coverage to their employees free from any penalty. First under the ACA, starting in 2015, large employers had to pay a penalty if they did not offer minimum essential coverage to at least 95% of their full-time employees (and their dependents), and at least one full-time employee received a subsidy or tax credit for purchasing coverage through an exchange. Annually, this penalty is \$2,000 (indexed for future years) for each full-time employee, excluding the first 30 employees.¹⁰⁰ Second, even where large employers offer minimum essential coverage to at least 95% of their full-time employees (and their dependents), they must pay a \$3,000 penalty for any

⁹⁸ See Zane Benefits, *New York Health Insurance Exchange Update – Plan Carriers and Rates* (July 26, 2013), <http://www.zanebenefits.com/blog/bid/306301/New-York-Health-Insurance-Exchange-Update-Plan-Carriers-and-Rates> (last viewed July 11, 2015) (analyzing New York State, *Approved Monthly Premium Rates – Individual Standard Plans*, <http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/Approved2014HealthInsuranceRates.pdf>) (last viewed July 11, 2015) (Computations by Zane Benefits and author).

⁹⁹ Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. 253 (2010) (codified at 26 U.S.C. § 4980H(a), (d)(2)(A)).

¹⁰⁰ Internal Revenue Serv., *Employer Shared Responsibility Provisions*, <http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions> (last viewed Sept. 14, 2015). A “full-time employee” is defined as one who works at least 30 hours a week. Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. 253 (2010) (codified at 26 U.S.C. § 4980H(d)(4)(A)). Under the transition relief provisions for 2015, the large employer penalty only applied to employers with at least 100 full-time workers. The penalty started to apply to all employers with at least 50 full-time workers in 2016. Internal Revenue Serv., *Transition Relief*, <http://www.irs.gov/Affordable-Care-Act/Employers/Transition-Relief> (last viewed July 1, 2015).

full-time employee who receives the premium tax credit for purchasing coverage through the marketplace.¹⁰¹

There is no penalty for small employers (defined as those with fewer than 50 full-time employees).¹⁰² Nor is there a penalty for employers that have employees making more than 400% of the federal poverty line or \$46,000 per family since those individuals would not be eligible for exchange subsidies in those states that have expanded Medicaid in accordance with the ACA. In states that have not expanded Medicaid to the ACA limits, the threshold would be the threshold amount that the state requires to qualify for Medicaid.

To recap, the ACA depends heavily on the individual mandate to reduce the number of uninsured and eliminate adverse selection in the individual market. Its penalties are too light, however, to drive enough healthy uninsured people to buy coverage. The same problem affects the large employer market, where some employers may find it profitable to treat the penalties as a cost of doing business without providing health coverage. Other medium-sized employers may lay off workers or reduce them to part-time work to come under the 50 full-time employee threshold. Meanwhile, small employers are not subject to a mandate at all.

To the extent that healthy individuals and employers can avoid coverage – either through payment of a penalty or, in the case of small employers, none at all – universal coverage will remain elusive and adverse selection is likely to persist in the individual market. Already, health insurers on the exchanges are seeking significantly higher rates for 2017 compared to 2016, on grounds that the individuals insured through the exchanges are much sicker than anticipated.¹⁰³ While it remains to be seen whether these insurers' claims about the extent of adverse selection are warranted, the weak penalty provisions of the ACA give cause for concern.

¹⁰¹ Internal Revenue Serv., *Employer Shared Responsibility Provisions*, <http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions> (last viewed Sept. 14, 2015).

¹⁰² *Id.*

¹⁰³ See Margot Sanger-Katz, *Get Ready for Higher Obamacare Rates Next Year*, N.Y. TIMES (May 6, 2016), http://www.nytimes.com/2016/05/07/upshot/get-ready-for-higher-obamacare-rates-next-year.html?_r=0.

C. THE CHALLENGES FACED BY INSURANCE COMPANIES IN THE SMALL GROUP MARKET

Clearly, the exchange marketplace is not a hospitable place for private for-profit and maybe not even for not-for-profit insurers. Due to the guaranteed issue provision, the risk for each insurer is virtually unlimited (though moderated somewhat by the reinsurance and risk adjustment mechanisms of the exchange).¹⁰⁴ Adverse selection is very real because the incentive penalties are so much lower than the premium costs of the broad exchange coverage, even when one considers the federal subsidy. In addition, there is no assurance that the exchange will attract the heterogeneous population, especially the younger healthier population, needed to distribute risk efficiently.

Already many healthy young people have decided to avoid the exchanges and just pay the penalty, arguing that it's a better deal for them financially. In addition, lack of public understanding and knowledge of the existence of the exchange has raised considerable doubt as to whether those who can benefit most from the exchange will apply. Providers of healthcare, and in particular hospitals and health insurers, are actively reaching out to the public because the absence of large pools and people insured by private companies and Medicaid will hurt their bottom line.

Compounding the problem of adequate heterogeneous pools, employers and their advisors are actively looking for ways to avoid the ACA's requirements. Many employers, even small employers, are considering self-insuring or obtaining stop loss to protect themselves from unexpected catastrophic claims.¹⁰⁵ Other employers are redefining their workforces so that they do not meet the full-time employment threshold.¹⁰⁶ Viewed in its totality, the future of private insurance in the exchange

¹⁰⁴ Patient Protection and Affordable Care Act, §§ 1341-1343, 124 Stat. 208-213 (2010) (codified at 42 U.S.C. §§ 18061-18063). For discussion of those reinsurance and risk adjustment mechanisms, *see, e.g.*, GAO, *supra* note 97.

¹⁰⁵ *See, e.g.*, PlanSponsor, *No Rush to Self-Insure Health Benefits Yet*, June 17, 2015, <http://www.plansponsor.com/No-Rush-to-Self-Insure-Health-Benefits-Yet/> (last viewed July 1, 2015).

¹⁰⁶ *See, e.g.*, Karen McVeigh, *US Employers Slashing Worker Hours to Avoid Obamacare Insurance Mandate*, THE GUARDIAN, Sept. 30, 2013, <http://www.theguardian.com/world/2013/sep/30/us-employers-slash-hours-avoid-obamacare>; ObamaCare Facts, *ObamaCare Employer Mandate*, <http://obamacarefacts.com/obamacare-employer-mandate/> (last viewed July 1, 2015).

context is bleak. Publicly traded private insurance companies remain cautious about participation in the exchanges, though they are slowly testing the waters.¹⁰⁷ This reluctance will persist, especially for companies that report quarterly and expect yields competitive with other public stock companies.

In the ACA, Congress assumed that the private insurance sector will continue to underwrite health risks for most of the non-elderly population. But nothing requires private insurers to continue to do so. To the contrary, the burdensome nature of the ACA's provisions is likely to eventually drive private insurers out of the individual health insurance market altogether. Meanwhile, large employers will chafe under their new obligation to provide health coverage under pain of penalty and will align with private insurers to shed their involvement in health insurance. They will be joined by the numerous individuals who discovered to their dismay that many of the subsidized plans that are marketed as affordable come with high deductibles and co-pays. With private insurers heading for the exits, employers following closely behind, and citizens demanding truly affordable health insurance with no costly hidden surprises, an odd coalition of forces will coalesce supporting change to a single-payer, government health insurance system.

III. THE ACA'S MOST ENDURING LEGACIES: FUNDAMENTAL RESTRUCTURING OF THE MEDICAL DELIVERY SYSTEM AND NEW POLITICAL COALITIONS THAT WILL CULMINATE IN TRUE UNIVERSAL HEALTH CARE

During the 20th century, the medical delivery system and third-party payers in the United States “grow’d like Topsy” into a sprawling fragmented universe that more often than not has multiple clinicians treating non-routine maladies with little or no coordination. Today, this fragmented system represents over one-seventh of the total U.S. gross domestic product¹⁰⁸ and is composed of many diverse stakeholders, both with respect to the delivery and payment of care.

¹⁰⁷ See, e.g., GAO, *supra* note 21, at 10-11.

¹⁰⁸ CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURE DATA: HISTORICAL, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last viewed June 28, 2015) (computations by editor).

According to recent statistics, there were over 5,600 U.S. hospitals (both profit and not-for-profit), almost 900,000 physicians practicing in many diverse structures in the U.S. (e.g., as sole practitioners, varying types of group practices, and employees of hospitals and other institutional providers, including state and local governments), over 800 third-party payers (a.k.a. insurance companies), and a number of federal and state government programs -- the latter providing over 40% of total medical expenditures.¹⁰⁹ Other stakeholders include pharmaceutical and medical service companies and allied professionals, such as nurse practitioners and chiropractors.

There are many reasons why the rate of rising medical costs threatens to exceed the growth of GDP, including technology, the volume-driven fee-for-service reimbursement methodology, and a professional and societal culture that embraces a “more is better” mentality. One of the most overlooked drivers of medical costs is the transaction cost of dealing with the large and diverse number of payment and delivery components of our balkanized health care system. Estimates vary, but most believe that changing from the current third-payer system to a government-run, single-payer system could reduce the annual cost of health expenditures in the U.S. – currently running at \$2.7 trillion -- by around 16%.¹¹⁰

Most of the stakeholders in the system make more under the fragmented volume-based system and therefore have a vested interest in perpetuating it. This Balkanized system historically deferred to the clinical decisions of professional clinicians (though this deference diminished

¹⁰⁹ *Fast Facts on US Hospitals*, AMERICAN HOSPITAL ASS'N, <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (last viewed July 1, 2015); CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURE DATA: NHE FACT SHEET, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> (last viewed June 28, 2015) (computations by editor); *Total Industry Overview*, INS. INFORMATION INST., <http://www.iii.org/fact-statistic/industry-overview> (last viewed July 1, 2015); *Professionally Active Physicians*, KAISER FAMILY FOUND. <http://kff.org/other/state-indicator/total-active-physicians/> (last viewed July 1, 2015).

¹¹⁰ See, e.g., Gerald Friedman, *Universal Health Care: Can We Afford Anything Less?*, *Dollars and Sense* (July 1, 2011), <http://www.pnhp.org/news/2011/july/universal-health-care-can-we-afford-anything-less>; Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, N.Y. TIMES, (June 1, 2013), http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?pagewanted=all&_r=0.

significantly over the last 40 years) and displayed a bias towards evaluating the efficacy of a particular product or practice considered alone rather than its effectiveness compared to alternatives. As a result, comparative little attention was paid to the marginal value of a particular intervention compared to its marginal cost.

The ACA changes this historic paradigm in several significant ways and the impact of these ACA changes will be amplified by the economic and demographic trends summarized in Section I of this Article. Many of these ACA initiatives will be more significant and enduring than the much-publicized ACA efforts to cover the uninsured through the exchanges and mandates.

The enduring ACA initiatives are based on several related assumptions: 1) the delivery system must be restructured so that every entity involved in a medical intervention is accountable for its outcome; 2) accountable clinicians should base their decisions on evidence-based medicine – in other words, best practices based on real-world clinical outcomes data and the marginal cost and therapeutic value of any intervention; 3) increased patient satisfaction and participation in the intervention process; and 4) changes in payment methodologies that align clinician reimbursement with the value rather than the volume of such interventions.

These ACA initiatives are intricately related but can be best described by breaking them into three basic categories: 1) value-based purchasing; 2) structural changes to the delivery and financing system; and 3) comparative effectiveness research.

While most of these initiatives focus on Medicare, most believe commercial and other government payers will soon follow suit in one form or another for a number of reasons: 1) Medicare is the largest payer for both institutional and individual providers and these clinicians will gravitate towards its processes; 2) other government payers, such as Medicaid and CHIP, will build on the Medicare initiatives; 3) commercial payers will try and differentiate their value-based purchasing (via branding and somewhat different approaches) and those providing Medicare Advantage will build their value-based purchasing efforts on the Advantage platform. Over time most stakeholders will gradually move towards the Medicare processes because Medicare will provide a “good housekeeping seal of approval” for branding purposes and because insurers, in the process, can reduce the transaction costs otherwise associated with multiple payment systems.

A. VALUE-BASED PURCHASING

Reduced to its essentials, value-based purchasing (VBP) is the restructuring of the historic reimbursement approach for medical care from one based on volume (*i.e.*, the fee-for-service system) to a more efficient healthcare system (in which the marginal therapeutic value of any intervention must exceed its marginal cost) that also pursues other desirable goals. VBP seeks to accomplish these objectives by linking part of healthcare reimbursements to quality measures.¹¹¹

Underlying these objectives is the belief that embracing this methodology will reduce or flatten the rate of rising healthcare costs while improving quality. Over the last 100 years, VBP has raised its head here and there (for example, in the form of the health maintenance organization, case management, and various other prepayment arrangements), but generally the U.S. healthcare payment system has been dominated by fee-for-service reimbursement.

Starting in the early 2000s, VBP received increasing attention, especially at the national level. Congress authorized VBP as a pilot project in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.¹¹² Pursuant to this legislative initiative, the Centers for Medicare and Medicaid Services (CMS) began implementing demonstration programs starting in 2003 that instituted VBP with respect to various healthcare providers, such as group practice physicians, hospitals, nursing homes and home healthcare services.

The ACA centralized oversight for these pilot programs under a new entity located in the Department of Health and Human Services (HHS) called the “Center for Medicare and Medicaid Innovation” (CMMI).¹¹³ The ACA will fund the center with \$10 million annually for 10 years to evaluate and identify new payment methodologies that will result in improved quality and savings.¹¹⁴

¹¹¹ See, e.g., Anita Archer & Judy Monestime, *CMS Value-Based Purchasing Program and ICD-10*, HIMSS NEWS, <http://www.himss.org/News/NewsDetail.aspx?ItemNumber=28816> (last viewed July 1, 2015).

¹¹² Pub. L. No. 108-173, §§ 501(b), 646, 17 Stat. 2289, 2324 (2003); see also Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5001, 120 Stat. 28 (2006).

¹¹³ Patient Protection and Affordable Care Act, § 3021, 124 Stat. 389 (2010) (codified at 42 U.S.C. § 1315a).

¹¹⁴ *Id.* § 3021, 124 Stat. 394 (2010) (codified at 42 U.S.C. § 1315a(f)).

These VBP pilot projects were and are being primarily carried out in a fee-for-service environment. Their main focus is on data collection, though several do so in the context of programs with real economic consequences for selected stakeholders, primarily hospitals. Among other things, the ACA requires HHS to create comparative websites for hospitals, physicians and other providers providing Medicare services. The initial websites will provide basic data on each provider and include outcomes data as those data become available.

Several recent HHS rulemakings regarding hospitals illustrate the type of programs being developed under the ACA. In 2012 HHS promulgated a rule designed to reduce acute hospital readmission rates. The program initially focuses on selected high-cost or high-volume conditions, such as heart failure and pneumonia. Starting in 2013, hospitals serving Medicare beneficiaries with high volume conditions, such as chronic heart failure, surgeries and infections acquired in hospitals, had to meet certain quality targets and if they did not, CMS would make progressive reductions in their Diagnosis-Related Group (DRG) reimbursement rate.¹¹⁵

In 2013, HHS initiated its hospital VBP program for inpatient stays in approximately 3000 hospitals across the country. Under this program, Medicare will adjust the hospital payment based on either: 1) how well the hospital performs compared to all hospitals in the area; or 2) how much the hospital's performance has improved compared to a defined prior baseline.¹¹⁶

¹¹⁵ Dep't of Health and Human Serv., *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers – Part II: Final rule*, 77 Fed. Reg. 53258 (Aug. 31, 2012) (codified at 42 C.F.R. pts. 412, 413, et al.); *see also* Dep't of Health and Human Serv., *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers: Final rule; correction*, 77 Fed. Reg. 60315 (Oct. 3, 2012) (codified at 42 C.F.R. pts. 412, 413, et al.); Patient Protection and Affordable Care Act, §§ 3001(a)(1), 3008, 124 Stat. 353, 376 (2010) (codified at 42 U.S.C. § 1395ww(o), (p)).

¹¹⁶ Dep't of Health and Human Serv., *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center*

Physicians are already submitting performance data and the ACA mandates a similar program for physicians by 2016.¹¹⁷ More and more of these types of programs will be expanded to other Medicare providers as time data and methodologies are deemed feasible based on the ongoing demonstration projects.

CMS has also established data collection activities in Medicaid and CHIP programs to facilitate the creation of similar projects with reimbursement repercussions for these payers.¹¹⁸ Pursuant to the ACA, other demonstration projects are setting targets for skilled nursing facilities and home health agencies.¹¹⁹ By 2016, targets will be established for psychiatric hospitals, prospective-payment-system (PPS)-exempt cancer hospitals, hospice centers, long-term care hospitals, and rehabilitation hospitals.¹²⁰

At the same time a number of other HHS and commercial entities are experimenting with bundled payments for situations where multiple providers participate in a particular medical intervention.¹²¹ The ACA has taken the bundled approach one step further: the ACO program -- which is not a demonstration pilot but the creation of a new type of entity that will be able to contract directly with Medicare and share in any savings the new entity realizes relative to a predetermined average benchmark

Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals – Part III: Final rule with comment period and final rules, 78 Fed. Reg. 74826 (Dec. 10, 2013) (codified at 42 C.F.R. pts. 405, 410 et al.).

¹¹⁷ Patient Protection and Affordable Care Act, § 3007, 124 Stat. 373 (2010) (codified at 42 U.S.C. § 1395w-4(p)).

¹¹⁸ See Dep't of Health and Human Serv., *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers – Part II: Final Rule*, 77 Fed. Reg. 53258, 53503-04 (Aug. 31, 2012) (codified at 42 C.F.R. pts. 412, 413, et al.).

¹¹⁹ Patient Protection and Affordable Care Act, § 3006, 124 Stat. 372 (2010).

¹²⁰ *Id.* §§ 3004, 3005, 124 Stat. 368, 371 (2010) (codified at 42 U.S.C. §§ 1395cc, 1395f(i), 1395ww).

¹²¹ See, e.g., CTRS. FOR MEDICAID AND MEDICARE SERVS., BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) INITIATIVE: GENERAL INFORMATION, <http://innovation.cms.gov/initiatives/bundled-payments/> (last viewed July 6, 2015).

reimbursement under Medicare's fee-for-service and DRG methodology.¹²² The ACO program will be discussed in the next section.

B. MAJOR STRUCTURAL CHANGES IN THE DELIVERY AND REIMBURSEMENT SYSTEM

The ACA contemplates a new type of network of physicians and hospitals called an accountable care organization whose members agree to share responsibility for healthcare provided to patients. Under the ACA, an ACO agrees to manage all of the health care needs of at least 5,000 Medicare beneficiaries for three years or more.¹²³

The ACO structure is voluntary.¹²⁴ It is designed to facilitate seamless quality care and to make all of the clinicians involved collectively accountable for the care each provider provides to an individual patient. Providers are “rewarded” with bonuses for slowing the growth of Medicare healthcare costs while meeting performance standards, including patient satisfaction standards.¹²⁵

Under the final rule defining the contours of ACOs,¹²⁶ there are 33 quality standards that focus on four key areas: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations (people who are frail or elderly).¹²⁷

The ACO structure is available to physicians in group practices, networks of individual physicians, partnerships or joint venture arrangements among hospitals and participating physicians, hospitals employing physicians, and other providers and suppliers determined by the HHS secretary to be eligible for the program.¹²⁸ Notably, non-clinicians

¹²² See Patient Protection and Affordable Care Act, § 3022, 124 Stat. 395 (2010) (codified at 42 U.S.C. § 1395jjj).

¹²³ See *id.*; Jenny Gold, *Accountable Care Organizations Explained*, NAT'L PUBLIC RADIO (Jan. 18, 2011), www.npr.org.

¹²⁴ See, e.g., Dep't of Health and Human Services, *Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program* (2015), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf.

¹²⁵ *Id.*; Gold, *supra* note 123.

¹²⁶ Dep't of Health and Human Services, *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule*, 76 Fed. Reg. 67802 (Nov. 2, 2011).

¹²⁷ *Id.* at 67889-90.

¹²⁸ *Id.* at 67808.

must work through clinicians,¹²⁹ which will enhance physician autonomy vis-à-vis third party payers and other non-clinician “partners.”

An ACO must meet certain criteria and be approved by HHS. Key conditions include: 1) a governing body representing ACO providers and patients; 2) accepting responsibility for at least 5,000 Medicare fee-for-service beneficiaries; and 3) providing a detailed plan acceptable to the secretary regarding how the ACO plans to deliver quality and lower the growth of expenditures, including procedures for routine self-assessment monitoring and the reporting of care it provides plus a process to use the data to continually improve the ACO's quality and cost performance.¹³⁰ This latter provision expects ACOs to be active practitioners of evidence-based medicine.

Once certified, the ACO must participate in the program for at least three years.¹³¹ CMS can terminate the program if the ACO fails to comply with the eligibility and program requirements.¹³²

While certified ACO structures may vary somewhat, each must meet the general requirements listed above. Conceptually the foundation of the ACO will be primary care physicians, responsible for treating groups of patients linked together with participating specialists, hospitals, and electronic records systems.

Any certified ACO that meets the plan quality standards will be eligible to receive a share of the saved earnings relative to a predetermined and updated benchmark. The final rules also provide that an ACO may choose a higher shared savings rate if it agrees to share in any losses.¹³³

Contemporaneous with this ACO “shared savings” rulemaking, CMS’s “innovation center” released a demonstration project for smaller ACO entities that are physician-owned or located in rural locations to receive advance payments (of up to \$250,000) for investments in infrastructure and caregiving staff.¹³⁴ CMS also unveiled a series of demonstration projects providing for provider remuneration based on bundled payments for an episode of care -- where all providers involved in

¹²⁹ *Id.*

¹³⁰ *Id.* at 67807-08, 67816-30.

¹³¹ *Id.* at 67807, 67977.

¹³² *Id.* at 67982-83.

¹³³ *Id.* at 67909-12.

¹³⁴ See CTRS. FOR MEDICAID AND MEDICARE SERVS., ADVANCE PAYMENT ACO MODEL, <http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/> (last viewed July 6, 2015).

treating a patient will share in the bundled or single episode payment.¹³⁵ Clearly the end goal of “shared savings” is to align provider incentives with health outcomes – in other words, to create accountability.

Another important Medicare cost containment measure involves the ACA’s changes to the Independent Medicare Advisory Board (IMAB).¹³⁶ IMAB is a 15-member agency¹³⁷ designed to strengthen the Medicare Payment Advisory Commission (MedPAC). MedPAC’s job for many years was to make recommendations to achieve specific savings in Medicare without affecting coverage or quality.¹³⁸ The old MedPAC had no power whatsoever because any of its recommendations had to be approved by Congress.¹³⁹ Of MedPAC’s many recommendations over the years, none was approved by Congress.

The new IMAB has roughly the same charge – to make proposals to Congress to “reduce the per capita rate of growth in Medicare spending”¹⁴⁰ – but its power is enhanced by its structure. First, each member is appointed by the president for staggered terms with advice and consent of the Senate.¹⁴¹ Second, IMAB’s recommendations automatically go into effect unless Congress adopts an equally effective recommendation with approval by both houses, including at least three-fifths of the

¹³⁵ See CTRS. FOR MEDICAID AND MEDICARE SERVS., BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) INITIATIVE: GENERAL INFORMATION, <http://innovation.cms.gov/initiatives/Bundled-Payments/> (last viewed July 6, 2015).

Other non-Medicare payers are beginning to explore bundling options. See Suzanne Delbanco, *The Payment Reform Landscape: Bundled Payment*, HEALTH AFFAIRS BLOG, (July 2, 2014), <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment>. Key to organizational decisions to embrace bundled payments are the availability of relevant data, a robust IT system with the analytical ability to evaluate outcomes, and the level and type of risk (operational or insurance) that providers are willing to accept.

¹³⁶ Patient Protection and Affordable Care Act, §§ 3403, 10320, 124 Stat. 489, 949 (2010) (codified in part at 42 U.S.C. § 1899A).

¹³⁷ *Id.* § 3403(a)(1), 124 Stat. 489, 502 (2010) (codified in part at 42 U.S.C. § 1899A(g)(1)(A)(i)).

¹³⁸ See David Newman & Christopher M. Davis, *The Independent Payment Advisory Board*, CONG. RESEARCH SERV. 30 (No. 7-7500, 2010).

¹³⁹ See *id.*

¹⁴⁰ *Id.* at 2.

¹⁴¹ Patient Protection and Affordable Care Act, § 3403(a)(1), 124 Stat. 489, 502-03 (2010) (codified in part at 42 U.S.C. § 1395kkk(g)(1)(A)(i)).

Senate.¹⁴² IMAB's cost control recommendations for Medicare consequently have significantly more teeth.

Still other significant changes, such as the shifting of Medicare funding for residencies in teaching hospitals to community hospitals and clinics,¹⁴³ are designed to reinforce the ACA's structural changes essential to a primary care/CER foundation, including the trend towards evidence-based medicine and advanced continuity and coordination of care.

While there is no "silver bullet" for better individual outcomes, better healthcare for populations, and lower expenditure growth, there is a widespread consensus that the best chance for meeting all three goals requires the alignment of provider treatments with accountability. There is also widespread consensus on the need for more evidence-based medicine and particularly the degree to which new procedures and practices provide better results than existing ones. Realizing evidence-based medicine and best practices is the ultimate goal of another primary ACA objective: comparative effectiveness research.

C. COMPARATIVE EFFECTIVENESS RESEARCH: AN IDEA WHOSE TIME HAS COME

1. What is CER?

Although we have in place a system to test the safety of drugs and medical devices, the Institute of Medicine estimates that over one half of all medical procedures have not been subject to rigorous evaluation.¹⁴⁴ The ACA attempts to change this by expanding the evaluation process to

¹⁴² See Timothy Stolfus Jost, *The Independent Payment Advisory Board*, 363 *NEW ENG. J. MED.* 103, 105 (2010); Newman & Davis, *supra* note 138, at 51. This procedure resembles the successful procedure instituted for recommendations on military base closings in the legislation establishing the Defense Base Closure and Realignment Commission. Topher Spiro, *The Independent Payment Advisory Board*, CENTER FOR AMERICAN PROGRESS (March 5, 2012), <https://www.americanprogress.org/issues/healthcare/report/2012/03/05/11269/the-independent-payment-advisory-board/> (last viewed June 16, 2016).

¹⁴³ Patient Protection and Affordable Care Act, § 5503, 124 Stat. 655 (2010) (codified in part at 42 U.S.C. § 1395ww(h)(8)).

¹⁴⁴ Inst. of Med., *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* 150-151 (Mark Smith et al. eds., 2012).

encompass all aspects of health care:¹⁴⁵ alternative medical delivery structures, alternative clinical interventions and alternative drugs and medical devices. Not all existing practices can be changed at once. Instead, they will be evaluated in stages in accordance with priorities established by the Institute of Medicine reinforced by an elaborate structure of clinical experts and other stakeholders in the system.

There is no uniform definition of CER, but the definition formulated by the former Federal Coordinating Council for Comparative Effectiveness Research is often used to describe it. CER, according to the Council, is:¹⁴⁶

[...]the conduct and synthesis of research *comparing the benefits and harms* of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in “*real world*” settings. The purpose of this setting is to improve health outcomes by *developing and disseminating evidence-based information* to patients, clinicians, and other decision-makers, responding to their expressed needs, about which interventions *are most effective for which patients under specific circumstances*.

Even this definition does not capture the true significance of CER, which can be best described by articulating how the present evaluation process works and its impact upon the way medical care is delivered and paid for today.

The traditional evaluation approach or clinical trial measures the efficacy of a particular treatment: that is whether the treatment produces or does not produce a marginal benefit in the artificial world of the laboratory measured against a randomized control group. The American Medical Association's characterization is revealing:¹⁴⁷

¹⁴⁵ For the ACA's provisions on comparative effectiveness research, see the Patient Protection and Affordable Care Act, §§ 3011, 3501, 6301(a)-(c), 124 Stat. 378, 507, 707-42 (2010) (codified at 42 U.S.C. §§ 280j, 299b-33, 299b-37, 1320e, 1320e-1).

¹⁴⁶ Federal Coordinating Council for Comparative Effectiveness Research, REPORT TO THE PRESIDENT AND CONGRESS 5 (2009) (emphasis added).

¹⁴⁷ *Advocacy with the Administration: Comparative Effectiveness Research*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/advocacy/federal/advocacy-with-administration.page> (last viewed July 10, 2016).

Most current research on medical treatments compares the benefits of a specific treatment to no treatment, but little information is available to physicians to help them determine if new treatments outperform existing options.

The differences between traditional evaluation and CER will have a profound effect upon the delivery and financial structure of medical care. More often than not, the traditional clinical trial focuses on comparing the “efficacy” of a given treatment to no treatment (via a “control group”), rather than also comparing the new intervention’s cost and outcome to existing alternative treatments. In addition, this traditional focus more often than not concentrates on new technology and whether a new procedure or product is safe “on average,” which dilutes or avoids ascertaining whether there would be similar or different outcomes for subpopulations based on age, gender, health status and other relevant factors.

The traditional evaluation process fits into the prevailing medical paradigm, *i.e.*, that something new is always better across-the-board. It fits into the prevailing reimbursement paradigm of fee-for-service -- the more you do, the more money you make. Both reinforce “for-profit” as opposed to “not-for-profit” medicine.

Of even greater importance, the traditional evaluation process does not measure whether the incremental benefit of a new intervention outweighs its incremental cost. This is a highly relevant indicator, along with how the new technology’s outcomes compare with existing alternatives, of the *efficiency* of the new medical intervention.

CER’s potential for cost-benefit analysis is greatly feared by many stakeholders in the present system, especially drug and medical device manufacturers. Another controversial aspect of CER is that its findings of best practices could be used to mandate a particular treatment under particular circumstances. Although the American Medical Association (AMA) has strongly endorsed CER, its focus has been on clinical outcomes and it is very explicit regarding the use to which CER findings could be put to use.¹⁴⁸

¹⁴⁸ *Principles for Comparative Effectiveness Research*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/advocacy/federal/advocacy-with-administration.page> (last viewed July 10, 2016) (emphasis added).

The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. . . . [S]ufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

It is noteworthy that while the AMA strongly embraces evidence-based medicine and comparative effectiveness research, it makes it very clear that professional autonomy regarding the use of CER findings is of key importance to clinicians. This theme permeates the ACA. For example, ACO governance is heavily dominated by clinicians.¹⁴⁹ Funds for building infrastructure emanate from the government for direct distribution to clinicians,¹⁵⁰ which reduce the dependence of clinicians upon non-clinician “deep pockets” for infrastructure capital. In addition, the ACA's bias

¹⁴⁹ Department of Health and Human Services, *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule*, 76 Fed. Reg. 67802, 67816-22 (Nov. 2, 2011).

¹⁵⁰ CTRS. FOR MEDICAID AND MEDICARE SERVS., ADVANCE PAYMENT ACO MODEL, <http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/> (last viewed July 6, 2015).

towards “not-for-profit delivery systems”¹⁵¹ strengthens the leverage of the profession regarding clinical decision-making.

Because many in the public equate limits of any kind as “rationing,” in view of the importance of clinical autonomy for the medical profession and the concerns of all stakeholders regarding the economic impact of CER, it is not surprising that a large part of the ACA's CER provisions deal with how CER is implemented.

2. Implementation of CER

Most agree that CER, if implemented to its full potential, will transform the medical professional paradigm.¹⁵² Many, however, are skeptical that CER will realize its potential, primarily for three reasons: 1) the restrictions the ACA places on the use of CER findings and evidence for Medicare and to a more limited degree recommendations to Congress by IMAB;¹⁵³ 2) the inclusion of non-clinician stakeholders in the governing mechanisms of CER; and 3) the historic reticence of clinicians to abdicate their autonomy regarding clinical decisions.

To be sure all three present challenges. However, these challenges are overstated and the way CER implementation is structured not only ameliorates these concerns by accident or elegant design but actually creates a structure that is best suited to realize CER's potential for clinicians and other stakeholders to adopt voluntarily identified and documented best practices and increased reliance upon evidence-based medicine. The following will first summarize the governing structure of CER and then describe how the structure overcomes the major concerns of skeptics.

CER is not a new concept and has been around for some time although its implementation has been fragmented in the U.S. It first became centralized with the American Recovery and Reinvestment Act of

¹⁵¹ See, e.g., Patient Protection and Affordable Care Act, §§ 1322, 10104(q), 124 Stat. 187, 903 (2010) (codified at 42 U.S.C. §§ 18042, 18054(a)(3)).

¹⁵² See, e.g., John Aloysius Cogan Jr., *The Affordable Care Act's Preventive Services Mandate: Breaking Down the Barriers to Nationwide Access to Preventive Services*, 39 J.L. MED. & ETHICS 355 (2011) (arguing that the ACA's requirement that public and private health plans provide evidence-based preventive services with no out-of-pocket costs effectively transforms those plans into vehicles for promoting public health).

¹⁵³ See Patient Protection and Affordable Care Act, §§ 3403(a)(1), 6301(c), 124 Stat. 490, 740 (2010) (codified at 42 U.S.C. §§ 1320e-1(a), (c)(1), 1395kkk(c)(2)(A)(ii)).

2009 (ARRA), which appropriated \$1.1 billion to fund CER among three agencies: the Department of Health and Human Services, the NIH and the Agency for Healthcare Research and Quality (AHRQ).¹⁵⁴

ARRA also created a public entity, the Federal Coordinating Council for Comparative Effectiveness Research, to coordinate CER efforts at the federal level.¹⁵⁵ The Institute of Medicine (IOM) also was given the responsibility to establish national priorities for CER¹⁵⁶ and IOM recommended 100 critically important initial topics for CER research.¹⁵⁷

The ACA builds upon these concepts and creates a new not-for-profit corporation that the ACA stresses is “neither an agency nor establishment of the United States government.”¹⁵⁸ The new entity is named the “Patient-Centered Outcomes Research Institute” (PCORI), which replaces its predecessor, the Federal Coordinating Council for Comparative Effectiveness Research.¹⁵⁹

PCORI is directed by a board of governors composed of the heads of NIH and AHRQ and 17 other members selected by the General Comptroller. Three board members represent patient and consumer interests. In addition, there must be five physicians and provider representatives, including at least one surgeon, nurse, integrative healthcare practitioner, and hospital representative. Other representatives must include three private payers, including at least one to represent self-funded employers. Pharmaceutical, medical device, and diagnostic firms have three representatives. Finally one board member must be an independent health service researcher and the two remaining members must represent state and federal health agencies.¹⁶⁰

PCORI’s mission is to advance the “quality and relevance of evidence” available to patients, physicians, payers, and policymakers.¹⁶¹ Its

¹⁵⁴ American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, tit. VIII, 123 Stat. 177 (2009).

¹⁵⁵ *Id.* § 299b-8.

¹⁵⁶ *Id.* § 3.

¹⁵⁷ See Inst. of Med., *100 Initial Priority Topics for Comparative Effectiveness Research*, <http://iom.nationalacademies.org/~media/Files/Report%20Files/2009/ComparativeEffectivenessResearchPriorities%20Stand%20Alone%20List%20of%20100%20CER%20Priorities%20-%20for%20web.ashx> (last viewed July 7, 2015).

¹⁵⁸ Patient Protection and Affordable Care Act, § 6301(a), 124 Stat. 728 (2010) (codified at 42 U.S.C. § 1320e(b)(1)).

¹⁵⁹ *Id.* §§ 1320e(b)(1), 2996-8.

¹⁶⁰ *Id.* § 1320e(f)(1).

¹⁶¹ *Id.* § 1320e(c).

responsibilities are to identify research priorities, analyze evidence identifying the relevance of current evidence and economic effects, and advance broad dissemination of research findings.¹⁶²

The ACA specifically directs PCORI to pursue “comparative clinical effectiveness research,”¹⁶³ which the ACA describes as head-to-head comparisons of “health care interventions, protocols for treatment, care management and delivery procedures, medical devices, diagnostic tools, pharmaceuticals . . . , integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.”¹⁶⁴

Part and parcel of PCORI’s efforts is to provide information to educate patients so that patients will play a more pivotal role in treatment decisions and their relationship with their physicians.¹⁶⁵ Whether or not PCORI will be able to ameliorate the asymmetry of information between doctor and patient and the cultural dominance of clinicians in the doctor-patient relationship remains to be seen.

PCORI has considerable human and dollar resources at its disposal.¹⁶⁶ Among other things, it has a nationally recognized Executive Director and a large staff of experts to evaluate research proposals and make decisions regarding these proposals.¹⁶⁷

Transparency and checks and balances are to be assured by a requirement that PCORI submit a draft of research priorities for public comment prior to formal adoption.¹⁶⁸ The ACA further limits the use of PCORI’s conclusions for purposes of Medicare.¹⁶⁹

The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII [Medicare] if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

¹⁶² *Id.* §§ 299b-37, 1320e(c), (d)(1)-(d)(2).

¹⁶³ *Id.* § 1320e(b)(3), (d)(6)(C).

¹⁶⁴ *Id.* § 1320e(a)(2)(B).

¹⁶⁵ *Id.* §§ 299b-37, 1320e(c).

¹⁶⁶ *See id.* §§ 1320e(b)(3), (d), 1320e-2.

¹⁶⁷ *Id.* § 1320e(d)(6), (f)(1)-(f)(2), (f)(6).

¹⁶⁸ *See id.* § 1320e(d)(6)(C)(i), (h)(1).

¹⁶⁹ *See id.* § 1320e-1(a).

In addition, PCORI is specifically prohibited from adopting “QALY” or similar thresholds for establishing what types of care are cost-effective.¹⁷⁰ Medicare decisions cannot be made “in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than” an individual who is not.¹⁷¹ Similarly, the Secretary of HHS is specifically prohibited from adopting a QALY or similar metric for establishing what types of care are cost-effective.¹⁷²

These ACA limitations conclude by saying “nothing in . . . [the ACA should] be construed as superseding or modifying the coverage of items or services . . . that the Secretary [of HHS] determines are reasonable and necessary under” existing law.¹⁷³

- (b) Nothing in section 1181 shall be construed as –
 - (1) Superseding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1162(l)(1); or
 - (2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative clinical effectiveness research.

Though these limitations appear severe and far-reaching, they do not apply to voluntary professional clinical decisions under Title XVIII. Nor do these limits apply beyond HHS Medicare regulations. The new IMAB is subject to roughly the same restrictions although the language is different and appears somewhat narrower in scope.¹⁷⁴

¹⁷⁰ “QALY” is a metric consisting of a “quality-adjusted life year.” QALY adjusts the value of a year of added life by the quality of life that year. See Nat’l Inst. for Health and Clinical Excellence, *Measuring Effectiveness and Cost Effectiveness: The QALY* (Apr. 20, 2010), <https://www.nice.org.uk/proxy/?sourceurl=http://www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenessstheqaly.jsp>.

¹⁷¹ Patient Protection and Affordable Care Act, § 6301(c), 124 Stat. 740 (2010) (codified at 42 U.S.C. § 1320e-1(c)(1)).

¹⁷² See *id.* § 1320e-1(d)(1).

¹⁷³ *Id.* § 1320e-1(b).

¹⁷⁴ *Id.* § 1395kkk(c)(2)(A)(ii).

[An IMAB] proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

Consequently, despite the vagaries of these statutory limitations, it is clear that Congress preferred that PCORI's findings and evidence and IMAB's recommendations be implemented "voluntarily" by clinicians.

3. Potential obstacles to the implementation of CER

Most skeptics emphasize the ACA's CER Medicare restrictions as the main impediment to successful implementation of CER. To be sure, the process restrictions on the use of PCORI findings and research are significant, but they are not as onerous as the skeptics claim.

First, the restrictions are limited to decisions within Medicare coverage, and to a more limited degree to cost control recommendations by IMAB. The restrictions do not limit the use of PCORI findings for other government programs and private sector coverage. Second, the transparency process, which is much like federal rulemaking, will often result in a better product if the old adage "more heads are better than one" has any efficacy. Many regulators have found that stakeholders -- even those opposed to a proposed regulation -- often come up with better ideas or find mistakes that the regulators overlooked. When these deficiencies are identified in the public comment process, regulators have a chance of correcting them. Even if there are no deficiencies and stakeholders are adamant in their opposition, the regulator gets the additional advantage of knowing what issues will be opposed, the arguments for those positions and the opportunity to develop counter-arguments. A PCORI finding or evidence that successfully runs the required ACA procedural gauntlet will only have its legitimacy and credibility enhanced, which will greatly increase the chances of acceptance by clinicians.

Skeptics also believe that non-clinician stakeholders participating in PCORI governance will greatly increase the danger of regulatory capture. For the very same reasons articulated above, the ACA process mitigates this danger and in fact may reduce the risk of such capture considerably.

The third major concern articulated by skeptics relates to the absence of a mandate for clinicians to accept PCORI findings. Skeptics point to the historic reticence of clinicians to give up any autonomy and in particular to give it up to the government. This argument overlooks the fact that the polestar of PCORI is *voluntary* acceptance of its findings and/or evidence. Whether or not clinicians will accept or reject PCORI findings and/or evidence remains to be seen. Clinicians will certainly prefer the PCORI process to the restrictions imposed by the insurance industry over the last 40 years. In addition, odds are that credible PCORI findings and/or evidence will be accepted by clinicians, especially if PCORI is viewed as “a trusted source.” Although it has been amply documented (including through John Wennberg's small practice variations studies¹⁷⁵ and initiatives such as the Dartmouth Atlas of Medicine¹⁷⁶) that clinician decision-making has an aspect of “herd” autonomy -- that is, clinicians, at least to date, have been influenced more by the professional socialization process, *i.e.*, where they went to school and what their peers do, than by evidence when making clinical care decisions – there is growing evidence in recent years that clinicians are increasingly embracing evidence-based medicine.¹⁷⁷

In sum, either because of political necessity, accident or elegant design, PCORI's focus on transparency and voluntary adoption by clinicians appears to be the optimal route to the implementation of CER and evidence-based medicine for clinicians.

IV. PROGNOSIS (OR A BETTER TITLE ANYONE? SUCH AS “PULLING IT ALL TOGETHER.”)

Despite the bungled rollout of the ACA and resulting public confusion over the ACA's access options, exchanges, mandates and subsidies, the ACA has resulted in expanded coverage for some 16.4

¹⁷⁵ See, *e.g.*, Klim McPherson, John E. Wennberg, Ole B. Hovind & Peter Clifford, *Small-Area Variations in the Use of Common Surgical Procedures: An International Comparison of New England, England, and Norway*, 307 NEW ENG. J. MED. 1310 (1982).

¹⁷⁶ *Dartmouth Atlas of Health Care*, <http://www.dartmouthatlas.org/> (last viewed June 28, 2015).

¹⁷⁷ See, *e.g.*, Atul Gawande, *Overkill*, NEW YORKER, May 22, 2015, at 42, 52-53; Earl P. Steinberg & Bryan R. Luce, *Evidence Based? Caveat Emptor!*, 24 HEALTH AFFAIRS 80 (2005).

million uninsured¹⁷⁸ through the prohibition of pre-existing exclusions, expanded age participation for dependents on parents' policies, and Medicaid expansion in those 29 states plus the District of Columbia that opted for expansion under the ACA. Now that the "glitches" that manifested themselves during the rollout are being remedied, more will be covered not only through the exchange market but also by Medicaid since one of the functions of the exchanges is to refer Medicaid eligibles to the government program.

Even so, public opinion regarding the ACA and the President remains sharply divided and repeal or substantial change is not beyond the realm of possibility if the Republican Party captures the White House and both houses of Congress in 2016.

However, any change will not be quite as expected largely because of benefits from the ACA itself and the societal changes described in Section I of this Article. Even if those favoring repeal come into ascendancy, their options will be severely limited due to the millions of newly covered uninsureds. Even those who were already insured when the ACA went into effect are weary of change and uncertainty and these uncertainties and anxiety will force those that advocate change to be very cautious -- especially as the employer's role diminishes.

Any new changes will create turmoil and shift public opinion from the existing distrust of ACA's real or perceived coercion regarding the individual mandate to an environment that underscores the absolute need for and practicality of having coverage. This need has been embraced by most of the stakeholders and is of particular importance to institutional providers and large portions of the individual medical community. While some elements of the population and clinicians are still holding out, in the end practicality will trump the historic infatuation with free choice.

The changes that do occur or have the most likelihood of occurring will be limited to ACA's "free-market" access programs discussed in Section II. The lasting and enduring legacies of the ACA discussed in Section III of this Article will remain in place for several reasons.

¹⁷⁸ Department of Health and Human Services, *Health Insurance Coverage and the Affordable Care Act* 1 (May 5, 2015), http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf (last viewed July 8, 2015). That represents a 35% reduction in the number of uninsured individuals from 2013 (the final year before the ACA fully went into effect) through first quarter 2015. *See id.*

First and foremost will be the new and expanded political constituencies favoring direct coverage rather than guaranteed access accompanied by evidence-based medicine and greater clinical autonomy that exists today over clinical decisions. For example, between 2014 and 2020, the Medicare population is projected to increase by 21% to 54.8 million beneficiaries¹⁷⁹ due to the onset of retirement for the baby boomers. Over the same period, the Medicaid population is projected to increase by 12%, to 65 million,¹⁸⁰ due to the 29 states and the District of Columbia that have opted into the program and the likelihood that other states will change their mind and will welcome at least 10 years of fiscal relief from Medicaid liabilities.¹⁸¹ Many also believe the Medicaid population will increase also because the gap between the have and have-nots will increase rather than decrease. Institutional providers and individual clinicians will support this increase in Medicare and Medicaid participation to ensure cash flow for their operations.

The medical clinicians will consolidate for the same reasons. The growth of ACOs will accelerate for similar reasons as well as for another very important one: the ACO structure leverages clinician power vis-à-vis other stakeholders and restores to them a fair amount of the autonomy they had lost to third-party payers over the last 40 years.

¹⁷⁹ CTRS. FOR MEDICAID AND MEDICARE SERVS., NATIONAL HEALTH EXPENDITURE DATA: PROJECTED, NHE PROJECTIONS, 2013-2023 – TABLES, tbl. 1, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html> (last viewed July 9, 2015) (computations by editor).

¹⁸⁰ Robin Rudowitz, *A Look At CBO Projections For Medicaid and CHIP*, KAISER FAMILY FOUND. (June 5, 2014), <http://kff.org/medicaid/issue-brief/how-much-will-medicare-cost-in-the-future-and-why-a-look-at-federal-projections/> (last viewed July 8, 2015) (computations by editor).

¹⁸¹ To encourage states to sign up for Medicaid expansion, the ACA stipulated that the federal government would pay for 100% of that expansion through 2016. Starting in 2017, the federal contribution will drop slowly every year and then plateau at 90% in 2020 (and for all subsequent years). See Matt Broaddus & January Angeles, *Federal Government Will Pick Up Nearly All Costs of Health Reform's Medicaid Expansion* (Center on Budget and Policy Priorities, March 28, 2012), <http://www.cbpp.org/research/federal-government-will-pick-up-nearly-all-costs-of-health-reforms-medicare-expansion> (last viewed July 8, 2015); Patient Protection and Affordable Care Act, § 2001(a)(3)(B), 124 Stat. 272 (2010) (codified at 42 U.S.C. § 3696d(y)).

Last but not least, the employer community (both large and small) is eager to move rapidly away from employers' traditional role as sponsors of health plans either by no longer providing such plans, encouraging employees to move to the exchanges, or shifting to a defined contribution rather than defined benefit environment. New employers in particular will be loath to go back to the system of the last 60 years.

All of these constituencies have a similar agenda: 1) shifting actual or moral responsibility for healthcare plan formation and administration from the private sector to the government; 2) a belief that healthcare efficiencies will only be realized through universal participation (a large diversified group with resulting cross subsidies and uniform procedures); and 3) a consensus that healthcare efficiencies can be best realized through "evidence-based medicine" and best practices. This latter consensus is even embraced by the medical community as long as clinical autonomy is restored and best practice findings are "voluntary" and considered by clinicians as emanating from a "trusted source."

For these reasons the enduring legacies described in Section III of this Article will remain in place as long as the VBP/CER protocols are maintained. Diverse participation in decision-making, transparency and voluntary acceptance are essential to CER being a "trusted source."

The ACA may also have another benefit though this in my mind is more of an aspirational than a likely result. Maybe stated a better way is that these aspirational hopes will be the most difficult to overcome.

The ongoing dialogue regarding the flawed ACA rollout hopefully will educate the public that the private model is not sustainable, equitable or workable. Hopefully the dialogue will educate the public that we are all in this together. Hopefully the young invincibles will realize that the need for medical care for them is not an option or in the "if" category -- instead it is just a matter of "when" -- which can happen at any time whether by sickness or accident.

The ACA debate will also hopefully educate the body politic that there is no benefit or plan known to man that does not have limits, because we do not have infinite resources. In addition, life itself has limits and this may be the most difficult concept for any of us to accept. Hopefully the ACA will help by giving all of us the grace to accept that fact.

ADOPTION DISRUPTION INSURANCE: A POLICY THAT AMERICA IS NOT READY TO ADOPT

GREGORY J. CHASE¹

Insurance and adoption seem like two ideas that can co-exist and mingle with one another. Yet, how have only a few people even ever heard of the term adoption insurance? Adoption is a market that seems fairly constant as there will always be a sizeable number of Americans interested in going through the process. There also seems to be little risk, especially since adoption disruption for domestic adoptions here in the United States occur at very low rates. So where did the miscommunication occur when adoption insurance finally was created? Who is to blame for the failure of the pioneered adoption disruption insurance? Is it possible to see adoption disruption insurance, like the one created by Philadelphia Insurance Company, in the United States any time soon?

Well, most people might think adoption and insurance are two words that do not fit together. Not surprisingly, the two have only recently overlapped. The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for example, were created with provisions that allowed adopted

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children to be insured underneath the adopting parents' health insurance. These new laws mandated health insurance companies, which already provided employer-sponsored health insurance plans that covered dependent children, to allow adopted children to be included in those policies as if they were no different than biological children. But these types of laws seem to be the extend of how much the two words will ever overlap.

One might think that the low rates of adoption disruption in America combined with the sometimes unbearable costs to adopt would bring about an avenue for insurance companies to mold a viable adoption disruption policy. But these two factors only describe a small portion of the factors that are involved in going through with an adoption. One of the major factors to those pursuing adoption is privacy. Insurance companies, like Philadelphia Insurance, might contend that their overlooking of the privacy factor deemed to be fatal to their attempt at creating an adoption disruption policy. But why is privacy such an important factor?

Some of the reason privacy remains so important is because a few high-profile adoption terminations brought about a large amount of public disapproval for the families who terminated their adoptions. Thus, potential adopting parents are less willing to tell insurance companies, or anyone really, that their adoption fell through because of them.

Currently, former adoption disruption policies are mostly unknown to the public as many individuals, adopting parents and non-adopting persons alike, do not know such policies exist. It seems that, based on insurance companies' last attempt to bring about interest in the policy, for years to come people will only view adoption disruption insurance as a myth.

INTRODUCTION

Adoption is a wonderful and beautiful thing. It is a process whereby a couple or individual choose to take in, love, cherish, and treat another child from someone else as if they were a member of their own biological family. It is an opportunity for children who have been abandoned, neglected, or lost amidst a collection of personal dilemmas by their birth mother, birth parents, or biological family to find a place where they can be given a chance to love and be loved, to grow, and to dream. It is also an opportunity for those who would not be able to have a child naturally due to biological factors, such as infertility, or have not been

successful in having a child by other means to start or to add to their family. But as beautiful and wonderful as adoption is, it does not always come to fruition once a couple, family, or individual set out to go through with it.

Adoption disruption and adoption dissolution are the two overarching major reasons adoptions fall through. Adoption disruption is used to describe an adoption that is terminated after the child is placed in his or her new adopted home but before the adoption is legally finalized.² On the other hand, adoption dissolution is used to describe an adoption process in which the child has been placed in his or her new adopted home and the adoption has been legally finalized but the legal relationship, or guardianship, has been severed, either voluntarily or involuntarily.³ Both, however, result in the adopted child being returned to, or possibly entered into, foster care or even placement with new adoptive parents.⁴ However, since American adoption insurance policies focus on adoption disruption, so will this article.⁵

Adoption disruption can occur for many reasons. A primary reason why adoption disruption occurs is because, despite often intense and meticulous screenings on possible future adopting parents, the adopting parents had or have unrealistic expectations of the child or themselves. This can be due to the child having developmental or psychological issues that the parents were not fully informed of during the adoption process and recognize they cannot handle. In fact many adopted persons lack the ability to find or look at the family genetic and medical history records of the child they intend to adopt at the child's birth.⁶ This information is critical to the diagnosis and treatment of genetically based medical and psychological conditions of a person.⁷ Upon discovering the seriousness of

² U.S. DEP'T OF HEALTH AND HUMAN SERV., CHILD WELFARE INFO. GATEWAY, ADOPTION DISRUPTION AND DISSOLUTION 1 (June 2012) [hereinafter CHILD WELFARE INFO. GATEWAY].

³ *Id.*

⁴ *Id.*

⁵ Telephone Interview with Laurie Goldheim, President, AdoptionAttorneys.com (Nov. 13, 2014).

⁶ See Evan B. Donaldson, *For the Records II: An Examination of the History and Impact of Adult Adoptee Access to Original Birth Certificates*, DONALDSON ADOPTION INST., July 2010, available at http://adoptioninstitute.org/old/publications/7_14_2010_ForTheRecondsII.pdf (explaining how the lack of medical and genetic records can cause a multitude of issues not only for adopted children but also those adopting them).

⁷ *Id.*

these developmental issues or psychological issues, newly adopting parents may realize that they are unable to connect to the child or that they are unable to mentally, physically, or even financially make the required adjustments of parenting the adopted child.⁸

This realization can occur before the adoption is finalized but can also occur months, even years, after the adoption is completely legalized.⁹ There is also the unfortunate reality that sometimes the adopted child and the adopted parent just do not get along. Therefore, in considering the best interest of all parties, the adoption is terminated. Adoption disruptions and adoption dissolutions are despairing but it doesn't mean that they are deserving of the extremely harsh and negative stigmatism that can be associated with them.

Although, adoption disruptions and dissolutions are saddening, especially if the child is sent back to a run-down or impoverished orphanage or a non-welcoming foster home. But they can also be beneficial for the child if he or she is able to, and desires to be, reunited with his or her biological parents. However, a few very high-profile disruptions and dissolutions have tarnished the options in the minds of many Americans and, in effect, turning a great deal of potential parents away from the idea and opportunity of adopting.

The first high-profile adoption disruption/dissolution reached the public on February 10, 2000 when CBS News' *48 Hours* told the story of Jesse and Crystal Money titled "The Perfect Child".¹⁰ The Moneys were a loving couple from the Atlanta area who had adopted a nine-year-old Russian girl. Ultimately the couple returned the girl, given the pseudonym Samantha, back to the orphanage in Moscow because the child had severe reactive attachment disorder, was mentally disabled, and often angry and destructive.¹¹ The Moneys could no longer pay for the psychiatric care and

⁸ CHILD WELFARE INFO. GATEWAY, *supra* note 2, at 3 – 5, 7.

⁹ See U.S. DEP'T OF HEALTH AND HUMAN SERV., CHILD WELFARE INFO. GATEWAY, IMPACT OF ADOPTION ON ADOPTED PERSONS (Aug. 2013) (describing the impact of adoption on adopted children while also briefly explaining some of the difficulties that adoptive parents may face post-adoption).

¹⁰ *48 Hours: The Perfect Child* (CBS News television broadcast Feb. 10, 2010).

¹¹ *Id.* There was even one incident where Samantha, after threatening to kill the Money's two-year-old son Joshua, recklessly held the child over a thirty-foot deck. After this incident the Moneys had to send their son to live with his grandmother in Texas until they had returned from sending Samantha back to Moscow for fear of Joshua being severally injured. Walter Goodman, *Television Review; An Adoption Dream Turns Nightmarish*, N.Y. TIMES, (Feb. 10, 2010),

could no longer risk the safety of their son so they tried to find a new family for her in America.¹² However, when the Moneys were unsuccessful in finding her a new family, due to Samantha's psychological and mental issues, they brought her to a psychiatric hospital in Russia and surrendered their adoption rights.¹³ Watching Samantha, an innocent child just looking for a loving home, being sent back and abandoned is extremely powerful but what is equally powerful, if not more powerful, are the words of the *48 Hours* reporter Troy Roberts. Roberts summed up the negative stigma when he stated that Samantha was abandoned because she had been deemed to be "defective merchandise" to the Americans who adopted her.¹⁴

It should be to no surprise that stories like the Moneys' and other stories of similar nature – some not even from the United States – have brought about an extremely critical eye on those couples or individuals who resort to adoption disruption and adoption dissolution.¹⁵ This stigmatism is causing individuals and couples to shy away from adoption for fear that the process might not succeed and adoption disruption or dissolution might have to become an unfortunate reality for them. However, these incidents are rarities among the overall population of adopting parents and should not be the lens to look at these avenues with.

This article attempts to clarify the history that adoption and insurance share. It also tries to acknowledge the failures of the short-lived adoption disruption insurance policy and why they occurred while also trying to predict whether or not those failures can be corrected or altered. Part I of this article intends to discuss how society and insurance have interacted in the realm of adoption in the past by primarily looking at the

available at <http://www.nytimes.com/2000/02/10/arts/television-review-an-adoption-dream-turns-nightmarish.html>.

¹² *48 Hours*, *supra* note 10.

¹³ *Id.* Samantha was unaware that the parents were bringing her to a hospital back in Russia. The television program makes the viewer very aware of this, only furthering the negative stigma that adoption dissolution is tasteless and cruel.

¹⁴ Goodman, *supra* note 11.

¹⁵ See Clifford J. Levy, *Russia Calls for Halt on U.S. Adoptions*, N.Y. TIMES, April 10, 2010, at A1 (describing how an American woman in Tennessee sent her adopted seven-year-old son back to Moscow by himself with a typewritten note stating that the boy was violent and a danger to her and her family so she no longer wanted him); see also Ciara Dwyer, *The Curious Case of Tristan Dowse*, INDEPENDENT, (Aug. 2, 2009), <http://www.independent.ie/life/family/mothers-babies/the-curious-case-of-tristan-dowse-26512267.html> (recounting the story of an Irish family who adopted an Indonesian boy only to later abandon him at an orphanage in Indonesia after the adoption "hadn't worked out").

way health insurance evolved to apply to society's demands for adoption during the 1990s. Part II aims to look at how society and insurance are currently interacting in the realm of adoption. This section of the article plans to look at a particular adoption disruption insurance policy underwritten by the Philadelphia Insurance Company and why it failed in what would seem like a healthy market. In looking at the particular insurance policy this article hopes to examine some of the demographics of who is adopting children, who is being adopted, what is the state of adoption insurance, who is aware of adoption insurance or that it even exists, and lastly how, if at all, adoption insurance reacted to or changed the current day market for adoption. Finally Part III will discuss the possibility of adoption insurance being rejuvenated and revived in America in the near future. Specifically, this section will look at the attitude that adopting parents have towards the notion of adoption insurance and the attitude of insurance underwriters and brokers in trying to bring back an adoption policy in the future. Ultimately, the attitudes of society have control over the future of the adoption and adoption insurance market just as they did in the 1990s. So even though today there remains to be optimal statistics to fuel the idea and possibility of adoption insurance to exist, it is the people's desire not to have the institutional creation of adoption insurance that trumps.

I. THE RELATIONSHIP OF THE ADOPTING COMMUNITY & INSURANCE IN THE PAST

Prior to the 1990s health insurance under general employers did not cover adopted children nor did they cover adopted children who were adopted with preexisting conditions.¹⁶ However, discrimination against adopted children by health insurers is officially prohibited today due to a variety of federal and state legislation. Two of the biggest federal laws to shape the background and foundation between the relationship of adoption and insurance are the Omnibus Budget Reconciliation Act (OBRA-93) of 1993 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These two pieces of federal legislation are the first two major acts that really put the tensions that were rising between adoption and insurance into the public eye.

¹⁶ Mark T. McDermott, *It's the Law: Health Insurance for Adopted Children*, ADOPTIVE FAMILIES MAG., March/April 2002, at 55.

In the years leading up to the passage of OBRA-93 the situation for parents trying to find health insurance for an adopted child worsened. The reason is because a greater number of employers and insurers decreased their risks by dropping or limiting coverage for groups like adopted children or families with adopted children.¹⁷ Two of the most significant problems prior to OBRA-93 was that insurance companies were often not willing to insure an adopted child until the adoption was final, which took sometimes several years to finalize the adoption, and that most insurance companies would not cover children with preexisting conditions.¹⁸

Before passage of the OBRA-93 amendment, the decision by a health care provider to offer coverage for an adopted child from the beginning of placement to after finalization of the adoption was discretionary on the part of the provider.¹⁹ This meant that families wanting to adopt had to often pay for the medical treatment of the adopted child, and sometimes the biological mother, out of pocket. Such expenses could be outrageously high and extremely burdensome if the child did indeed have a preexisting condition such as an illness, mental handicap, or a physical disability.

Organizations like the Adoptive Families of America (AFA), a non-profit organization that was focused on collecting information about and on adoptive families and the problems/successes they had, decided that they were going to show lawmakers that the dilemmas imposed by insurance companies in the 1980s and early 90s were making it extremely difficult for future parents to adopt and for those with adopted children to finance their adoptions.²⁰ It was clear that help was needed because there was an apparent discrimination by the insurance companies against parents of adopted children and the adopted children themselves.²¹

The AFA had collected dozens of stories on American families who were financially crippled from insurance companies' unwillingness to insure their adopted children, especially the children who had special needs.²² These stories include one of a Minnesota family who had to pay

¹⁷ Steve Humerickhouse, *The 1993 Amendment to ERISA: The Cure for an Adoptive Family Problem*, 6 LOY. CONSUMER L. REV. 12, 12 (1993).

¹⁸ *Id.* at 13.

¹⁹ *Will Health Insurance Cover an Adopted Child?*, PERS. HEALTH INS., <http://www.personalhealthinsurance.com/will-health-insurance-cover-an-adopted-child/> (last visited Nov. 22, 2014) [hereinafter *Will Health Insurance Cover*].

²⁰ Humerickhouse, *supra* note 17, at 13.

²¹ *Will Health Insurance Cover*, *supra* note 19.

²² Humerickhouse, *supra* note 17, at 14. There was a file on a family from Ohio who had six adopted children and in order to receive health care coverage for

approximately \$200,000 a year for a foster-child with a severe disability because their labor union plan refused to cover the child.²³ The family argued for health insurance coverage for the child if they were to finalize the adoption and no insurance company was willing to cover the not-yet-adopted child, which inevitably led to the family sending the child back into a foster home.²⁴ Due to stories like those reported by the AFA and a societal demand for legislation that OBRA-93 was put into legislation and signed by President Clinton on August 10, 1993.²⁵

OBRA-93 was significant for adoption advocates because it amended the Employee Retirement Income Security Act (ERISA) of 1974 to require group-employee health plans to provide coverage for adopted children as if they were the employee's biological children.²⁶ OBRA-93 also prohibited insurance carriers from limiting coverage of adopted children because the child was adopted with preexisting conditions.²⁷ But as great as OBRA-93 was, it was limited because the changes only applied to employers subject to ERISA, which did not cover government employers with employee sponsored plans.²⁸ The solution to this was HIPAA and its amendments to ERISA and its extensions of OBRA-93.

Before HIPAA but after OBRA-93 there were still several issues. Government employees were not able to obtain the same coverage for their adopted children from their insurance policies as were their private sector counterparts. OBRA-93 also allowed for adopted children to be denied coverage if the employee, who was the adopted parent of the child, did not enroll the child during the "open enrollment" period at work.²⁹ This had the potential to force adopting parents to wait almost a year to get their adopted child onto their health insurance coverage. Although one year might not

them, because their health insurer did not, the father had to get an agreement from his boss that his employer would pay him no more than \$15,480 a year in order for their family to become eligible for Medicaid.

²³ *Id.* at 13.

²⁴ *Id.*

²⁵ *Will Health Insurance Cover*, *supra* note 19.

²⁶ Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, 374-78 (1993) [hereinafter OBRA-93]; McDermott, *supra* note 16, at 55.

²⁷ *Id.*

²⁸ McDermott, *supra* note 16, at 55. These federal regulations only apply to employer-sponsored plans and therefore do not effect individual plans because those are regulated by the individual states.

²⁹ *Will Health Insurance Cover*, *supra* note 19 ("[Open enrollment] is a time period, usually around six weeks long, which occurs once a year and in which employees can make changes to their healthcare plans.").

sound like a completely debilitating factor, it definitely was for families with special needs children.³⁰

Another issue that hampered the effectiveness of adoption reform was that even if individual states made significant strides in state insurance law it did not aid an employee, who is an adopting parent, when they moved to another state or were transferred to another state by his or her employer.³¹ In fact, by the time HIPAA was signed in the summer of 1996, forty-four states had enacted laws limiting the duration of pre-existing condition coverage exclusions for private health care plans.³² However, the adopting community once again put pressure on the federal legislature to enact change to both private and public sector employment-insurance policies.³³ Constituents all across the country demanded continual reform to the ERISA and OBRA-93 legislative acts and they made sure their respective members of Congress heard their expectations, frustrations, and desires about availability and portability of insurance for adopted children.³⁴

Once again it was the month of August that the adoption community saw change at the federal level. But this time it was on August 21, 1996 that President Bill Clinton signed and enacted HIPAA.³⁵ This piece of legislation amended ERISA, in part, through its extension of OBRA-93. It extended the prohibition against discriminatory limitations by insurance carriers on adopted children, including those with preexisting conditions, to government employees.³⁶ This resulted in health insurance becoming available for adopted children of employees covered by group health plans, including government positions, the moment those families

³⁰ Humerickhouse, *supra* note 17, at 13 (describing how the lack of coverage for a special needs foster-child forced a Minnesota couple to pay \$200,000 a year which resulted in the incompletion of the adoption).

³¹ Colleen E. Medial, *HIPAA and its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 496 (1998).

³² *Id.* at 497.

³³ *Id.* One Senate report on the issue stated that approximately eighty-one million Americans were suffering from preexisting medical conditions in 1995. See S. REP. NO. 104-156, at 3 (1995).

³⁴ Brian K. Atchinson & Daniel M. Fox, *The Politics of the Health Insurance Portability and Accountability Act*, 16 HEALTH AFF. 146, 148 (1997).

³⁵ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

³⁶ Atchinson, *supra* note 34, at 147.

assume financial responsibility for the adopted child.³⁷ HIPAA specifically “prohibit[ed] the imposition of pre-existing condition coverage exclusions, irrespective of the individual’s lack of prior creditable coverage [for] adopted children under age eighteen enrolled in the plan within thirty days of adoption or placement for adoption.”³⁸

It seems fair to say that the impact of OBRA-93 and HIPAA were absolutely positive in terms of providing a way for adopting parents the ability to have their adopted, or soon-to-be adopted, child(ren) insured under their health care coverage. But now what needs to be analyzed is whether or not those two acts and the increase of insurance coverage for adoption resulted in an increase of adoptions. Society was impacting the insurance industry by demanding more and using their congressman to make that change.³⁹ But was insurance reform impacting society? Was the increase in coverage creating an increase in adoptions? The number of variables required to make a reliable and definite correlation are probably too vast. However, statistics show that the insurance reform was probably a factor that helped spur the increase in adoptions.

In 1992, the year before OBRA-93 was enacted, 127,441 children were adopted in the United States.⁴⁰ This is a large increase from 1986 when approximately 104,000 children were adopted.⁴¹ That jump of over twenty-thousand children adopted in a year is significant considering that roughly during the same time period the number of women placing their children for adoption in the United States declined.⁴² There was also a

³⁷ McDermott, *supra* note 16, at 55.

³⁸ Medial, *supra* note 31, at 499; 29 U.S.C.A. § 1181(d)(2).

³⁹ Atchinson, *supra* note 34, at 148.

⁴⁰ Nat’l Adoption Info. Clearinghouse, *Numbers and Trends*, ADOPTION.COM, <http://statistics.adoption.com/information/adoption-statistics-numbers-trends.html> (last visited Nov. 16, 2014) (referencing statistics from V. Flango & C. Flango, *The Flow of Adoption Information from the States*, NAT’L CTR. FOR STATE CTS. (1994)).

⁴¹ C.A. Bachrach et al., *On the Path to Adoption: Adoption Seeking in the U.S.*, 53 J. MARRIAGE & THE FAMILY 705, 705–18 (1991).

⁴² See Kristin A. Moore et al., BEGINNING TOO SOON: ADOLESCENT SEXUAL BEHAVIOR, PREGNANCY, AND PARENTHOOD 6 (1995) (noting that the total number of children being placed up for adoption had decreased and that was partly because only two-percent of unmarried women at any age placed their children in adoption by 1992); see also C.A. Bachrach et al., *Relinquishment of Premarital Births: Evidence From the National Survey Data*, FAMILY PLANNING PERSPECTIVES, 24, 27–32, 48 (1992) (indicating that the decline in numbers of women placing their children for adoption is primarily due to the declining numbers of white women

drastic increase in international adoptions. In 1992, there were over 6,500 international adoptions into the United States.⁴³ That number more than doubled by 1997 when over 13,600 children were adopted internationally and brought into the United States.⁴⁴

Looking at the national statistics it is difficult to determine whether or not the insurance companies increase in coverage is responsible for the increase in adoption but it appears that it was society's demand for post-adoption services and support was the catalyst for changes in insurance.⁴⁵ In fact the increase of adoption was so rapid in the 1990s that scholars felt policy makers needed to "recognize the long-term commitments to the [adopted] children" that adopting parents were making because "each adoption is also an extended financial commitment of adoption assistance resources."⁴⁶ Insurance had already been shown to be one of those important resources to make sure adoptions prevailed and avoided disruption or dissolution.⁴⁷ Again, although this is not conclusive it does show the adopting community's power to create change and that the change they create, such as that through legislation, can be extremely impactful on the growth of adoption in the United States.

Now even though adoption dissolution and adoption disruptions were not well reported at the time – not that they are well reported today

placing their children for adoption since minority women placing children in adoption has relatively remained the same from the mid-1980s to early 1990s).

⁴³ Nat'l Adoption Info. Clearinghouse, *supra* note 40 (indicating that 6,536 children were adopted internationally in 1992).

⁴⁴ *Id.* (showing that 13,620 children in 1997 according to the U.S. Department of State).

⁴⁵ Fred H. Wulczyn & Kristin Brunner Hislop, *Topic #2: Growth in the Adoption Population*, Issue Papers on Foster Care and Adoption 17 (2002), available at http://www.chapinhall.org/sites/default/files/old_reports/89.pdf.

⁴⁶ *Id.* at 18. The quote mostly was in reference to government funded adoption assistance; welfare. However, scholars Wulczyn and Hislop reference and show that in the 1990s and even early 2000s adoption was increasing at a rate where it was hard for policy makers to recognize the complexities and long-terms needs of the adopted children and adopting parents. It makes perfect sense to relay this comparison to that of the insurance companies and their policy underwriters since it seemed apparent they were reacting to society in the OBRA-93 and HIPAA legislative acts of the period as well.

⁴⁷ This is seen with the Minnesota family who was forced to return their child back to foster care due to the enormous insurance payments required to take care of their adopted child with a preexisting condition. Humerickhouse, *supra* note 17, at 13.

either – there were still statistics gathered on how many adoptions were failing. In 1998 it was discovered that over eighty percent of adoptions did not disrupt before the adoption was finalized and that over ninety-eight percent of adoptions that were finalized and legalized did not terminate.⁴⁸ Throughout the 1990s adoption displacement and dissolution rates constantly remained between six and twelve percent,⁴⁹ with the higher end applying to older children and the lower end to infants.⁵⁰ Plus, there was a slight improvement from the mid-1980s to mid-1990s in the decreasing overall number of adoption disruptions in the United States.⁵¹ Whether or not this is a result of the insurance reform is unknown. However, all of the statistical data and the history of the creations of OBRA and extensions through HIPAA do show us two important things.

The first is that the adopting community and the general society as a whole have the ability to make significant laws and policies that not only shape the market of insurance but also the market and process of adoption. If the adopting community believes there is a serious issue that infringes on their ability to adopt or to raise their adopted child(ren) then they will come together and pursue change. However, there has yet to be a public demand for adoption insurance. Does this mean that the adopting community does not believe there is a need for it or a desire for it? Or is the adopting community trying to tell us something else?

⁴⁸ See Victor K. Groza & Karen F. Rosenberg, CLINICAL AND PRACTICE ISSUES IN ADOPTION: BRIDGING THE GAP BETWEEN ADOPTEES PLACED AS INFANTS AND AS OLDER CHILDREN 2–9 (1998) (discussing the adoption population, the adoption process, and the issues that can and often do lead to disruption and dissolution of the adoption).

⁴⁹ R. M. Goerge et al., *Adoption Disruption and Displacement: The Illinois Child Welfare System, 1976–94* (U. Chi. Chapin Hall Ctr. for Children, Discussion Paper CS-35, 1995).

⁵⁰ See generally Groza, *supra* note 48, at 2, 15 (noting how it is more likely to see adoption disruptions and dissolutions in older children than infants); see also Marianne Berry & Richard P. Barth, *Adoption and Disruption: Rates, Risks, and Responses* (1988) (finding that less than one percent of infant adoptions disrupt but for children at ages twelve to eighteen the disruption rate increases to over fourteen percent); Kathy S. Stolley, *Statistics on Adoption in the United States*, 3 FUTURE OF CHILDREN: ADOPTION 26, 31–32 (1993) (explaining that placements of older children and children with histories of previous placements and longer stays in the foster care system are more likely to disrupt).

⁵¹ Trudy Festinger, *Adoption Disruption: Rates, Correlates, and Service Needs*, CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 452–468 (G.P. Mallon & P.M. Hess eds., 2d ed. 2005).

Second, the past statistical information shows us that there was no major change in the percentage of adoptions that were disrupted over the concerned period of major insurance reform. Therefore, it is possible to conceive that the reason adoption disruption insurance has yet to flourish or even stay afloat in the U.S. insurance market is because adoption disruption is not considered to be a risk worth insuring. However, in order to see how important these two factors are in concluding whether or not adoption disruption insurance can become a sustainable policy in the near future, it is critical to look at how the adopting community has viewed one of the major attempts at bringing adoption disruption insurance to life.

II. THE RELATIONSHIP OF THE ADOPTING COMMUNITY & INSURANCE TODAY

The crossroads between society and insurance, in the realm of adoption, are slightly different from what they were like back in the 1980s and 1990s. However, insurance reform has continued to yield to society when it comes to making the first moves and demands of how to shape the relationship between adoption and insurance.

The current state of adoption today seems fairly optimistic considering that people all over the country still want to adopt and give children a home even though the economy has not been as strong as it was in the 1990s when adoption was on the rise. In 1997, the Evan B. Donaldson Adoption Institute conducted a benchmark survey of over 1,500 adults to examine public attitudes toward adopted children, adopting parents, and the process of adoption itself.⁵² That survey showed that about six in ten Americans, in 1997, had at least some personal experience with adoption and a third of those Americans surveyed had considered adopting a child at least somewhat seriously.⁵³ Just like in 1997, today about thirty percent of Americans have considered adopting a child and that includes about thirty-six percent of married women.⁵⁴ However, the pure number of children adopted doesn't always reflect this optimism.

Looking at the last decade of adoption statistics one would see that the pure number of children being adopted in the United States has

⁵² Princeton Survey Research Assocs., *Benchmark Adoption Survey: Report on the Findings*, EVAN B. DONALDSON ADOPTION INST. (1997).

⁵³ *Id.* at 14.

⁵⁴ CHILD WELFARE INFORMATION GATEWAY, PERSONS SEEKING TO ADOPT 2 (Feb. 2011) (“In 2002 there were 18.5 million women ages 18-44 who had ever considered adoption. . . . and 12.8 million women who had ever been married.”).

decreased.⁵⁵ But even with the decreasing numbers the “proportion of adoptions to all exits from foster care has been very consistent, at approximately twenty-one percent since the 2009 financial year.”⁵⁶ This should rejuvenate hopes of an adoption insurance market because it shows that even though the numbers are declining it is not because people do not want to adopt. In fact, the decreasing number in total adoptions makes perfect sense considering that the overall number of children in foster homes continues to decrease as evidenced by the number of children waiting to be adopted declining from 135,000 in the 2006 financial year to 102,000 in the 2013 financial year.⁵⁷ The continual trend of adoption shows that the market for adoptions is a constant and sizeable one. But with such a sizeable and constant market present in the arena of adoption the real question becomes, “how does insurance get involved?” Or even more importantly, “how come I’ve never heard of adoption insurance before?”

Well, today there are two basic avenues that individuals can use insurance to aid them in the financial planning of adoption. Adoption insurance can help prevent excessive financial loss if the adoption fails and the insurance can also help cover some of the expenses of an adoption, such as adoption-related fees.⁵⁸ The two avenues are not mutually exclusive and in fact often synonymous. Many adoption experts regard adoption disruption and adoption dissolution insurance as just falling under the overarching idea of “adoption insurance”.⁵⁹

⁵⁵ U.S. Children’s Bureau, *Trends in Foster Care and Adoption: FFY 2002 – FFY 2013*, U.S. DEP’T OF HEALTH & HUMAN SERV. 1, 3 (July 21, 2014), available at http://www.acf.hhs.gov/sites/default/files/cb/trends_fostercare_adoption2013.pdf (showing that the number of foster home adoptions in 2002 were 51,000 and in 2013 the number decreased to fewer than 51,000).

⁵⁶ *Id.* at 3.

⁵⁷ *Id.* (“The last decade showed a decline in the numbers of children in foster care . . . [albeit that] financial year 2013 shows a slight increase over the prior year from 397,000 children in American foster homes in [the] 2012 financial year to 402,000 in [the] 2013 financial year.”).

⁵⁸ *Adoption & Insurance: Adoption Disruption Insurance*, ADOPTION.COM, available at <http://insurance.adoption.com/>; Anna Glendenning, *Adoption Insurance*, FAMILIES.COM, available at <http://www.families.com/blog/adoption-insurance>.

⁵⁹ Telephone Interview with Goldheim, *supra* note 5; Telephone Interview with Charles Daniels, Commercial Broker for Rose & Kiernan, Inc. (Nov. 24, 2014).

But the intersection of insurance and adoption in this regard is very different than the way the two interacting in the 1990s with the OBRA-93 and HIPAA legislation. In the 1990s the issue was getting adopted children, especially those with preexisting conditions, covered underneath their adopted parent's employer-based health insurance.⁶⁰ However, in 2006 when the National Adoption Foundation approached the insurance broker Rose & Kiernan, Inc., as their exclusive managing general underwriter and endorser, and the Philadelphia Insurance Company, as a fellow insurance underwriter, with the idea for adoption disruption insurance they were focused on insuring Americans from the devastating financial loss that came with domestic adoptions being disrupted.⁶¹

The National Adoption Foundation was established by Norman and Judy Goldberg in 1994, a year after they adopted their daughter, because they wanted to "do something for families who wanted to adopt but lacked the necessary financial resources."⁶² Once again it was the American people that began the conversation of bringing adoption into the insurance realm, as they desired to solve some of the adoption procedure's most concerning issues. The Goldbergs' daughter impacted them so much that the jovial adopters wanted to do more. But now it was the insurance companies', not the legislators', chance to react to this desire of the people and attempt to transform it into a reality.

When the National Adoption Foundation and Rose & Kiernan first began discussing what the Adoption Disruption Insurance policy would entail, they were going off statistics that Mr. Goldberg had provided.⁶³

⁶⁰ See generally Humerickhouse, *supra* note 17 (describing the issues that adopting parents had with finalizing an adoption or maintaining the financial burden brought on through a finalized adoption prior to OBRA-93 and HIPAA in 1996).

⁶¹ Letter from Sean L. Hickey, Sr. V.P. of Rose & Kiernan, Inc., to Philadelphia Ins. Co. (2005) (on file with author).

⁶² Maureen Hogan, *Foundation Provides Financial Support to Adoptive Families*, 6 FOSTERING PERSPECTIVES (2001), available at http://www.fosteringperspectives.org/fp_vol6no1/foundation_provides_financial_support.htm. The National Adoption Foundation was and is a non-profit organization that provided support to families trying to adopt or families who finalized an adoption by distributing direct grants as well as offering low-interest, unsecured home equity loans and a low interest credit card program.

⁶³ See Letter from Hickey, *supra* note 61 (stating that "Mr. Goldberg ha[d] provided . . . some benchmark statistics" through several surveys that he conducted through a "comprehensive network of adoption agencies and attorneys" and the National Adoption Foundation's Database).

Based on surveys conducted by the National Adoption Foundation and its network of adoption agencies and attorneys the company analyzed that the “domestic non-completion ratio [of adoptions, also known as the rate of domestic adoption disruptions,] has ranged between 2.7% to 3.9% annually [and is] significantly higher with foreign adoption.”⁶⁴ It further calculated that with about 250,000 domestic adoptions occurring every year that “conservatively” three to six thousand policies could be sold a year.⁶⁵

The premise of the policy was to insure the cost of domestic adoptions only, covering the cost of minor enhancement coverages such as indemnifying the adopting parents for expenses paid to the birth mother or paid on her behalf after the adoption had been disrupted.⁶⁶ Many scholars of the time, including professor Richard Barth from the University of North Carolina and the parties involved in drafting the policy, held the same view of domestic adoption disruption, such that they believed “the best prediction for any adoption is that it will not disrupt [because] [t]he base rates of disruptions are so low and the precision of the disruption predictions so modest, that the most scientific prediction is that any individual adoption will succeed.”⁶⁷ With such a low disruption rate, a sizeable and constant market, and the belief that society really wanted the creation of such a policy, Rose & Kiernan accepted the proposition by Mr. Norman Goldberg and the first national adoption disruption policy was set in motion.

With the agreement between the parties made, the policy moved forward. The Philadelphia Insurance Company policy gave adopting parents the option of either a \$25,000 or \$30,000 limit of liability, which

⁶⁴ *Id.*

⁶⁵ *Id.* There is no information in the letter to indicate where the 250,000 domestic adoptions a year came from. It does mention that the National Adoption Foundation averaged about six thousand hits a day, therefore, it may be safe to assume that this type of information was at one point in time located on the non-profit organization’s website. NATIONAL ADOPTION FOUNDATION, <https://fundyouradoption.org/> (last visited Nov. 23, 2014) (searching the website there appears to be no database of any indication that in 2004, ‘05 or ‘06 the domestic adoption rate was 250,000 a year). In fact, a Philadelphia newspaper wrote that in 2006 researchers actually found that about 135,000 children were adopted each year in the United States. Jeff Gammage, *A New Face and Profile Emerge on Adoption*, PHILA. INQUIRER, Nov. 19, 2006, at A2 (sourcing the Evan B. Donaldson Adoption Inst.).

⁶⁶ Letter from Hickey, *supra* note 61.

⁶⁷ Richard P. Barth, *Risks and Rates of Adoption Disruption*, 3 ADOPTION FACTBOOK 381, 385 (1999).

included a \$10,000 sublimit for attorney fees and advertising expenses, and a \$1,000 or \$2,500 deductible.⁶⁸ It was predicted that the policy would gross in anywhere from \$7,500,000 to \$15,000,000 per year if the parties could “jointly consult and build a national business and strategic marketing plan” for their newly created policy/product.⁶⁹ But in coming up with the final details of this policy the partnership between Rose & Kiernan and the National Adoption Foundation sent out a survey, created by AIG Product Development,⁷⁰ to dozens of adoption agencies and adoption attorneys across the country so that they could “create a policy that would most meet the needs of adoptive parents.”⁷¹

The policy was inevitably made from the results of the survey with the belief that the adoption agencies and adoption attorneys would know adopting parents and their desires, expectations, and worries as well as the trend of the adoption market.⁷² Forty-two of the survey recipients responded to Norman Goldberg’s letter and completed AIG Product Development’s questionnaire; answering a total of fifteen broad questions ranging from the age of the adoption agencies’ and adoption attorneys’ clients, adopting parents, to the average price of the agencies’ or firm’s fees to help complete an adoption.⁷³ Results from the survey showed a variety of things that national surveys by adoption researchers had missed or omitted in the past because of the uniqueness of the questions being asked in this insurance survey.⁷⁴

One of the questions that was asked in the survey was “Annually, what percent of parents at your agency/firm complete each process of the adoption?” and then broke it down to the three steps in the adoption process; submission of the adoption application, approval for adoption, and lastly the legal finalization of the adoption.⁷⁵ Thirty-six of the forty-two participants in the survey replied that seventy-six to one hundred percent of their clients were approved for adoption but then only eight participants

⁶⁸ *Adoption Disruption Protection Plus Insurance Application*, PHILA. INS. COS. (June 2006) [hereinafter ADI Policy].

⁶⁹ Letter from Hickey, *supra* note 61.

⁷⁰ Letter from Norman Goldberg, Pres. & Founder of the Nat’l Adoption Found., to Charles Daniels, Rose & Kiernan broker (2004) (on file with author).

⁷¹ Letter from Norman Goldberg, Pres. & Founder of the Nat’l Adoption Found., to survey recipients (2004) (on file with author).

⁷² Telephone Interview with Daniels, *supra* note 59.

⁷³ Charles Daniels, *Adoption Protection Coverage Survey Results* (Jan. 2005)(on file with author).

⁷⁴ Telephone Interview with Daniels, *supra* note 59.

⁷⁵ Daniels survey, *supra* note 73 (referencing question two).

replied that same rate applied to their clients' adoptions being legally finalized.⁷⁶ On that same note, thirty participants responded that their clients' adoptions only saw their adoptions legally finalized at about fifty-one to seventy-five percent;⁷⁷ a number that would indicate domestic adoption disruptions were occurring much higher than they were in actuality.⁷⁸

The survey also went into what were the additional costs that adopting parents were taking on when their adoptions disrupted and what the estimated range of those expenses would be;⁷⁹ questions that had never been asked of the adoption community before.⁸⁰ The results to those answers indicated that the most prominent expenses lost in the disruption of an adoption were the fees the adopting parents would pay for the birthmother, mostly medical, and those fees ranged up to four thousand dollars.⁸¹ Attorney fees, which were estimated to range up to four thousand dollars as well, were considered the second-most likely fee for adopting parents to incur if the adoption were to be disrupted.⁸² But what is most interesting about the results to this question is that over thirty percent of the participants responded that adopting parents whose adoption was disrupted did not incur any additional costs.⁸³ What is equally as important, if not more important, as the fees that families incur from a disrupted adoption are the circumstances in which those fees or expenses would be reimbursed and what types of fees and/or expenses would then be reimbursed.⁸⁴

⁷⁶ *Id.* (examining the answers to question two).

⁷⁷ *Id.*

⁷⁸ See J.F. Coakley & J.D. Berrick, *Research Review: In a Rush to Permanency: Preventing Adoption Disruption*, 13 CHILD & FAMILY SOCIAL WORK 101, 101–12 (2008) (indicating that the rate of adoption disruptions ranges from about six to eleven percent). It is possible that the reason behind the difference in the rates of adoption disruption from the AIG survey and the national survey is because the AIG survey was focused on private adoptions whereas the national surveys most likely took into count all adoptions whether made through a private firm/agency or made through a government organization.

⁷⁹ Daniels survey, *supra* note 73 (referencing question 4).

⁸⁰ *Id.* (stating that when Rose & Kiernan looked for already published research results on questions like this, back in 2005, they could find nothing).

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.* Thirteen of the forty-two participants selected 'None' as their answer to question four indicating that there were no application fees, home study fees, agency fees, advertising fees, birthmother fees, attorney fees, or post-placement supervision costs that had to be incurred by the unfortunate adopting parents.

⁸⁴ Telephone Interview with Goldheim, *supra* note 5.

The nation-wide survey showed that over a quarter of adoption agencies or firms would not reimburse adopting parents any fee or expense that they might have incurred from an adoption disruption.⁸⁵ Of the remaining seventy-five percent of the survey respondents, about forty percent of them revealed that they would reimburse fees if the adopting parent were to die but did not feel there was an inclination to reimburse fees or expenses for adoptions that were terminated for a variety of other reasons such as pregnancy of the adopting parents, a change of heart by the birthmother, or serious illness or injury to an adopting parent.⁸⁶ But even in those particular scenarios that would warrant a reimbursement of fees and/or expenses by an adoption agency or attorney, the actual fees or expenses that would be reimbursed were limited. The most agreed upon fee or expense being reimbursed was for post placement supervision expenses; but even that had just over a third of the participants willing to reimburse such expenses.⁸⁷ With such limited reimbursements available for adopting families from adoption agencies and adoption attorneys the real questions became “how much would an insurance policy remedy this?” Furthermore, if there was a need for a remedy to the way agencies and attorneys were handling the adoption procedure fallbacks, how could an insurance company help remedy these concerns?⁸⁸

The answers to these sorts of questions became the foundation to whether or not Rose & Kiernan continued to pursue the proposal of Norm Goldberg as these questions were specifically in the survey to try and analyze whether society desired an insurance policy or would be receptive

⁸⁵ Daniels survey, *supra* note 73 (referring to question 5).

⁸⁶ *Id.* According to the results for question four, none of the responding adoption agencies or adoption attorneys believed that the pregnancy of the adopting parents warranted a reimbursement for fees or expenses, three would reimburse if the birth mother changes her mind, one if the biological father or biological grandparents of the child challenged the adoption, five for reimbursing adoptions that disrupted because of serious illness or injury of the adopting parent, and one respondent replied they would reimburse an adopting parent if the adoption failed because of an illness or injury of a significant family member.

⁸⁷ *Id.* (showing in question six that only fifteen participants were willing to reimburse, in the event of an adoption being disrupted, the expenses of post placement supervision).

⁸⁸ Telephone Interview with Goldheim, *supra* note 5 (“If an insurance company were to create a policy it would be important that the insurance was going to do more for the [adopting parents] than what the agencies and attorneys were already doing.”).

to one.⁸⁹ These results, if truly an accurate representation of the attitude of the adopting community, indicated that society would not only be interested in an adoption disruption policy but that they were indeed looking for it. The survey results showed that ninety-five percent of the respondents were regularly asked about how to protect lost expenses due to an adoption disruption or dissolution from adopting parents, ninety-five percent of adoption agencies and adoption attorneys believed an insurance policy protecting expenses due to adoption disruption or dissolution would be beneficial to adopting parents, and ninety-five percent of the respondents were unaware of there being a product out in the open market that would reimburse certain expenses in the situation of an adoption being terminated.⁹⁰ But with all of the survey results and all of the collectible adoption statistics indicating that an adoption disruption policy would be potentially lucrative and successful, why or how did the Philadelphia Insurance Company's *Adoption Disruption Protection Plus Insurance* policy fail?⁹¹ The answer to this question is best summed up by the various people that make up the adopting community.

One couple, a couple who adopted children internationally in the 1990s and considered adopting a third child domestically from Connecticut in 2002, believes that the reason something like the Philadelphia Insurance Company's adoption disruption insurance never took off is because the policy was not well advertised.⁹² The couple noted that when they were considering adoption this type of insurance did not exist but that "if it did [they] would have known about it" because, as they put it, "when you're looking to adopt children you always ask questions of friends, family,

⁸⁹ Telephone Interview with Daniels, *supra* note 59 ("[W]e needed to know whether or not the adoption community would be receptive to an insurance policy and the last few questions of our survey aimed to help us with that. . . . [T]he first few questions were there to really help us set the values and limits of our policy but the [last few] questions were there to get a pulse on [society's desire] for our policy.").

⁹⁰ Daniels survey, *supra* note 73 (referring to the survey results for questions nine through twelve).

⁹¹ Telephone Interview with Daniels, *supra* note 59 ("[T]he adoption disruption insurance policy was pulled from Philadelphia Insurance Companies after a little over a year.").

⁹² Interview with G--- & L---, Adopting Parents from Hartford, Conn., in Hartford, Conn. (Oct. 21, 2014). This couple requested that their names not be released in this article as they wanted to aid in answering questions regarding their experience and understanding of adoption but desired to maintain their anonymity for personal reasons.

coworkers, or whomever you know has gone through the process successfully and you research as much as you can. . . . Adoption [unlike childbearing] isn't natural so you tend to find yourself doing research on how to get the process started because it's not like you just go to the local store and ask for a child."⁹³

Charles Daniels, a commercial broker for Rose & Kiernan, Inc. and the man who lead the underwriting of Philadelphia Insurance Company's *Adoption Disruption Protection Plus Insurance* policy, argued that, although the policy probably could have been marketed and advertised more, the policy had a great deal of exposure and advertisement. He explained that the policy was heavily endorsed by the National Adoption Foundation, which at the time had one of the largest adoption websites on the web,⁹⁴ and the endorsement by twenty-four adoption attorneys, who hailed from eighteen different states and the nation's capital,⁹⁵ as well as a dozen or two adoption agencies and organizations across the nation.⁹⁶ So if it wasn't advertisement what could have it been to cause the quick dropping of the policy by the Philadelphia Insurance Company?

Laurie Goldheim, the president of AdoptionAttorneys.com, argued that the reason adoption insurance most likely failed is because of a combination of the premium, low risk for disruption in an infant birthmother adoption, and the history of adoptions being done without the need of insurance.⁹⁷ She emphasized the amount of research that individuals pursuing adoption often take,⁹⁸ explaining that most adopting

⁹³ *Id.*

⁹⁴ Daniels acknowledged that he no longer had any statistical proof to show that the National Adoption Foundation website was once one of the leading sites for adopting parents available. However, he did state that Rose & Kiernan would not have agreed to underwrite such a policy nor would Phila. Ins. Co. had been willing to put forward the insurance policy if they did not believe in the power and pull of the organization and Mr. Goldberg. Letter from Hickey, *supra* note 61 (“[Goldberg’s] website averages 6,000 hits per day!”). Daniels also acknowledges that the National Adoption Foundation has significantly downsized and its network shrunken since the death of Mr. Goldberg. The current National Adoption Foundation website can be seen at <https://naf.fundly.com/>.

⁹⁵ Letter from Norman Goldberg, Pres. & Founder of the Nat’l Adoption Found., to Geoff Green, Rose & Kiernan, Inc. (Jan. 19, 2005) (on file with author).

⁹⁶ Telephone Interview with Daniels, *supra* note 59.

⁹⁷ Telephone Interview with Goldheim, *supra* note 5.

⁹⁸ Rainbow Kids Magazine describes the research and planning efforts of a couple in their pursuit of adopting a seven-year-old girl from China. Janice Sisneski, *Adoption Disruption: When Love Isn't Enough*, RAINBOW KIDS MAG.

parents will save up for years in order to afford an adoption and therefore have already come to grips with the financial sacrifice that the endeavor requires.⁹⁹ This combined with the low risk of an adoption actually disrupting,¹⁰⁰ makes adopting parents feel the risk is so low that it is worth foregoing acquiring insurance and simply proceed with the adoption process, which was what had been done for decades, was and is often an easy choice, “a no-brainer.”¹⁰¹

Again Daniels argued against the idea that the premiums were the issue. He reasoned that because adopting parents had saved up for months or years to adopt that they were more than willing to spend the one thousand dollar or two-and-a-half thousand dollar premium that the Philadelphia Insurance Company adoption disruption policy required.¹⁰² The adoption disruption protection policy that Daniels and his colleagues underwrote does include a \$10,000 sublimit for attorney or adoption agency fees,¹⁰³ which is a significant amount to be reimbursed considering that a majority of adoption agencies and attorneys charge more than \$15,000 for their services.¹⁰⁴ Also the full amount of the policy could reimburse a family up to \$30,000 if the right circumstances fit within their policy.¹⁰⁵ This is a substantial amount of money to get back but it still did not entice or convince adopting parents to invest in the adoption disruption policy. Again the question here is why?

Daniels believes that the reason the adoption disruption policy failed is because the adopting community is just not ready for it. He emphasized that in his experience with the adoption policy and in his conversations with his friends, whom have adopted, he found that

(Jan. 1, 2006), <http://www.rainbowkids.com/adoption-stories/adoption-disruption-when-love-isn-t-enough-456> (“[The adopting parents] had been on adoption e-mail lists, talk[ed] to other parents of older adoptees for almost a year . . . They felt prepared by these families and also by their supportive adoption agency’s educational programs [that] they had participated in.”).

⁹⁹ Telephone Interview with Goldheim, *supra* note 5.

¹⁰⁰ See Coakley, *supra* note 78, at 104.

¹⁰¹ Telephone Interview with Goldheim, *supra* note 5.

¹⁰² Telephone Interview with Daniels, *supra* note 59.

¹⁰³ *ADI policy*, *supra* note 68.

¹⁰⁴ Daniels survey, *supra* note 73 (referencing question fifteen where thirty-two of the forty-two participants responded that their average agency/firm fees were north of fifteen thousand dollars).

¹⁰⁵ *ADI policy*, *supra* note 68.

“adoption is a private thing and that’s how people in the adoption community want to keep it. . . . [E]specially if the adoption fails.”¹⁰⁶

Echoing this sentiment was the adopting couple from Hartford. When asked if adoption disruption had impacted them, the couple had admitted that they themselves had faced adoption disruption.¹⁰⁷ The couple also explained that throughout the entire adoption process only a select group of family members, friends, and co-workers they could trust knew that the couple was even trying to adopt.¹⁰⁸ When the adoption was finally terminated, due to the birth mother deciding to keep the child shortly after the child’s birth, the adopting couple was devastated. They explained their feelings at the time of the disruption as such:

When we came home from [abroad]¹⁰⁹, without the little girl we expected to adopt, all we could think of was [that] our chance to be parents was taken away from us. . . . We didn’t care about the financial loss because at the time there was no insurance and we had made plans financially to save up for the adoption and for [the beginning of] taking care of a child. It was also something we didn’t talk about, even our close siblings and parents knew to give us space. . . . [W]e just didn’t want to talk about it.¹¹⁰

Such emotion and mental anguish is taxing upon a person and can really wither them down. The mere thought of having to discuss such a personal issue with an insurance company, broker, or any stranger seems frustrating and aggravating. When the Hartford couple was asked about whether or not they would have brought their adoption disruption to an insurance company for reimbursement – in the hypothetical that they had a policy like the one Philadelphia Insurance Company marketed – the couple said “absolutely not” because the potential of getting a few thousand

¹⁰⁶ Telephone Interview with Daniels, *supra* note 59.

¹⁰⁷ Interview with G--- & L---, *supra* note 92 (recounting that in the 1980s their international adoption was disrupted because the birth-mother decided to keep her child after it was born).

¹⁰⁸ *Id.*

¹⁰⁹ The country from which the couple attempted to adopt a child was stricken from their comment in order to maintain the anonymous nature of their identity as the two children they adopted a few years later were from the same country.

¹¹⁰ Interview with G--- & L---, *supra* note 92.

dollars back was not worth the agony and frustration filing the claim and telling, probably arguing, their story to a stranger for months.¹¹¹

So maybe Daniels was correct in that the pure private nature of adoption is the reason why the insurance policy that the National Adoption Foundation teamed up with Rose & Kiernan to create failed. Or maybe it was a combination of the various facts prior mentioned? Although exactly what caused the Philadelphia Insurance Company policy to fail is unknown, it does not mean that one cannot predict whether or not such a policy can be revived and reinstated into the market today. But if Daniels was correct in his assessment that the private nature of adoption was the major reason for the failure of the adoption disruption policy in the mid-2000s, then it would seem fair to say that such a policy would not be able to flourish today either.

III. IS IT LIKELY ADOPTION DISRUPTION INSURANCE WILL BE REVIVED IN THE FUTURE?

Although adoption disruption insurance did not succeed in prior years it does not necessarily mean it will fail again. In fact, one of the biggest dilemmas and concerns of adoption professionals is that the recent trends and initiatives to increase the number of adoptions, while also decreasing the time needed to finalize an adoption, might increase the number of future adoption disruptions and dissolutions in the country.¹¹² Thus the question becomes, is the fear of an increase in adoption disruptions enough of a concern to reinvigorate insurance companies to look into a new adoption disruption policy? Is it possible to look at what may have been the cause of the Philadelphia Insurance Company's adoption disruption policy's downfall and try to guess whether or not those issues could be remedied?

Now it is possible that the Philadelphia Insurance Company did not market their policy well enough and adopting parents who would have been

¹¹¹ *Id.* The couple admitted that they had no idea what the situation would have been like if they had insurance because the thought of adoption insurance would have been seen as ridiculous in the 1980s. However, the husband explained that he had been in a car accident and the retelling of that story over and over again to a stranger from the insurance company was awfully irritating. He mentioned that he thought he was being judged the entire time even though he knew he was in the right. But by the time the husband was able to collect the money owed him by the insurance company after years of arguing back and forth about particular details he said that the "money wasn't worth the frustration."

¹¹² CHILD WELFARE INFO. GATEWAY, *supra* note 2, at 7.

interested did not look to invest in the insurance simply because they knew nothing of it. Or maybe their policy was not inclusive enough to the adopting community and the restrictions to the coverage alienated a majority of the community who would have actually been interested in the policy.

The disruption policy that Charles Daniels managed the underwriting for had a very limited number of adoption disruptions that it would actually cover. In order to qualify for the adoption disruption insurance the adopting couple would have to be solely looking to adopt a child that was under two years of age, adopted from within the United States, and an adoption that occurred between the birth-mother and the adopting parents; adoption from foster homes did not qualify.¹¹³ Not only that, but the circumstances leading to the adoption disruption would be limited to covering situations where the birth mother decided to keep the child, the birth father challenged the adoption, or due to the death of an adopting parent.¹¹⁴ When both of these requirements are met the insurance will indemnify, to the agreed upon amount, expenses paid to the birth mother or paid on the birth mother's behalf but only if the reimbursable expenses were incurred while the policy was in effect but before the birth mother or birth parents announced their intention to keep the child.¹¹⁵ The problem with this type of policy, as mentioned in the previous section, is that these particular adoptions have an extremely low likelihood of an actual disruption occurring.

The fact that this policy was only geared to birthmother adoptions was the first problem since seventy-one percent of domestic adopting parents look to adopt from foster care.¹¹⁶ Echoing this fact is Joselyn Benoit, a Program Social Worker at the UConn Health Center's Adoption Assistance Program (AAP) in Farmington, Connecticut.¹¹⁷ Ms. Benoit

¹¹³ *ADI Policy*, *supra* note 68; Letter from Hickey, *supra* note 61; Telephone Interview with Daniels, *supra* note 59.

¹¹⁴ *ADI Policy*, *supra* note 68; Telephone Interview with Daniels, *supra* note 59.

¹¹⁵ Letter from Hickey, *supra* note 61 (adding that coverage typically included medical care, living expenses necessary for the birth process, counseling expenses of the birth mother on both the birth and adoption process, and travel expense needed to arrange the adoption). Adoption Assistance Program, University of Connecticut Health Center,

¹¹⁶ CHILD WELFARE INFO. GATEWAY, *supra* note 2, at 3.

¹¹⁷ Telephone Interview with Joselyn Benoit, Program Social Worker at Univ. of Conn. Health Center Adoption Assistance Program (Dec. 18, 2014). Information available at <http://aap.uhc.edu/contact/index.html>.

noted that children adopted through the Department of Children and Families (DCF) is much more common than private domestic adoptions primarily because of the fact that the state has various financial incentives to adopt children through such programs.¹¹⁸ Also, with the enactment of the American Taxpayer Relief Act of 2012 (ATRA), taxpayers that adopt children through DCF “can receive a federal tax credit for qualified adoption expenses [and can] exclude from their income adoption expenses that were paid [for] by an employer.”¹¹⁹ Therefore, people who truly want to adopt can do so in a manner that alleviates many of the stresses that exist in domestic private adoptions with adoption agencies.

Ms. Benoit, who worked at the private adoption agency Wide Horizons For Children¹²⁰ prior to her time with the UConn Health Center’s AAP, explained that because most families adopt from state foster homes and state adoption services like DCF, it “does not make sense [for them] to pay for an [adoption] insurance plan on an adoption that they will be paid for.”¹²¹ She further commented that with such a low-risk, if any, of a financial loss in these types of adoptions (currently the majority of adoptions), it makes “absolutely no sense for [potential adopting parents] to even consider investing in something like adoption [disruption] insurance.”¹²²

However, even if the policy were recreated and opened up to foster care adoptions, it seems unlikely that it would bring about a resurgence of

¹¹⁸ Such programs include the Dept. of Children and Families’ subsidized guardianship program. ADOPTION ASSISTANCE PROGRAM BROCHURE (2014), available at http://aap.uchc.edu/services/pdfs/aap_brochure.pdf. There are also Financial and Medical subsidies and even College Assistance/Post Secondary Education assistance. Post Adoption Services, CONNECTICUT FOSTER ADOPT (Jul. 7, 2015, 2:10:19 PM), <http://www.ctfosteradopt.com/fosteradopt/cwp/view.asp?a=3795&Q=447946>.

¹¹⁹ STAFF OF S. COMM. ON FIN., 112TH CONG., SUMMARY OF PROVISION IN THE AMERICAN TAXPAYER RELIEF ACT OF 2012: PRELIMINARY (Comm. Print 2013). The adoption tax credit is a one-time credit per child and if a person has received their adoption tax credit for an adoption, then they cannot apply for an additional adoption tax credit in future years. Federal Adoption Tax Credit, NORTH AMERICAN COUNCIL ON ADOPTABLE CHILDREN (Oct. 2014), <http://www.nacac.org/taxcredit/taxcredit.html>.

¹²⁰ The homepage for Wide Horizons for Children can be found at <https://www.whfc.org/>.

¹²¹ Interview with Benoit, *supra* note 126 (referring to the fact that the state has various tax incentives and financial aid incentives for families who do adopt for free-of-charge services).

¹²² *Id.*

interest due to the low risk of disruption of infant adoptions and the low cost of adopting children from foster homes.¹²³ Then there is the possibility of opening up the policy to international adoptions and marketing it to the largest group of adopting parents probably interested in adoption.¹²⁴ However, insurance companies have stated that they are not interested in opening up an adoption policy to international adoptions due to the higher rate of unpredictability and termination.¹²⁵

But even if they did, statistics show that international adoption disruptions are not significantly any more of a risk than domestic ones.¹²⁶ Plus, international adoptions tend to cost on average over \$28,800,¹²⁷ whereas most domestic adoption expenses cost less than \$5,000.¹²⁸ The increased cost might cause adopting parent(s) to look more seriously at a hypothetical adoption insurance. However, the low risk might cause them to forego insurance for international adoptions in the same manner that they would have foregone the insurance in a domestic adoption.

Furthermore, survey numbers reveal that the cost of adoption and the concern of disruption are no longer top priorities in adopting

¹²³ See Harris Interactive, INC. & Evan B. Donaldson Adoption Institute, National Adoption Attitude Survey 4 (2002) (explaining that although eighty-two percent of adoption-considering Americans fear the birth parents will want to try and regain custody once the adoption is complete, the actual rate of that happening is extremely low). Page four of the article explains that people who believe adoptions in the United States could be very expensive are unaware of how low the cost in foster care adoption is.

¹²⁴ Interview with G--- & L---, *supra* note 92 (acknowledging that from the 1980s to today that “it’s always been known [to people seeking adoption] that international adoptions carry more [of a] risk” than domestic adoptions of failing).

¹²⁵ Telephone interview with Daniels, *supra* note 59 (“[D]ealing with adoptions in every state requires enough [of an insurance company’s] resources to keep up to date with what each and every state determines is the length of time a birthmother’s right to cancel an adoption is. . . . [Insurance companies] won’t spend the money or resources to accompany a global market that isn’t even producing at a national or regional level.”).

¹²⁶ U.S. DEP’T OF STATE, FY 2013 ANNUAL REPORT ON INTERCOUNTRY ADOPTION 3, 5 (2014) (showing that out of 7,094 international adoptions that took place in the 2013 financial year only six were disrupted).

¹²⁷ *Id.* at 1 (calculating the median cost for all international adoption services to be \$28,845.85).

¹²⁸ Adoption USA, *National Survey of Adoptive Parents*, DEP’T OF HEALTH & HUMAN SERVS. (April 19, 2013) (revealing that fifty-five percent of domestic adoptions cost \$5,000 or less and that ninety-three percent of international adoptions cost more than \$10,000).

communities today.¹²⁹ It seems safe to say that, based on the presumption that families who are adopting have already financially prepared themselves,¹³⁰ adopting parents are more willing to take a gamble on the low risk than invest another few thousand dollars on an insurance that most likely won't apply to them or won't be needed.¹³¹ It was this same thinking that possibly caused the Philadelphia Insurance Company's adoption disruption to fail over seven years ago. But, based on the firm belief that the adoption disruption insurance's downfall was significantly, if not solely, on the premise that adoption is too personal and private of a matter to become marketed by adoption companies appropriately, the question becomes: Does this same attitude of personal privacy still trump other concerns and issues of adoption for adopting parents?

A grandmother of an adopted child attempted to address this issue when she retold the story of how her daughter almost didn't adopt because she was so afraid of the social stigmatism that could be attached to her if she failed to make the adoption work.¹³² She explained that her daughter had seen a story "about a woman in Tennessee who sent her adopted child back to Russia by himself because so she no longer wanted him"¹³³ and how the media was being extremely critical of her even though the child was extremely violent, and the daughter became very afraid of "adopting a child she was unsure of."¹³⁴ It is this same sort of stigmatism and public

¹²⁹ HARRIS INTERACTIVE, INC., *supra* note 123, at 28 (showing that only 7% of the 1,416 adopting parents surveyed were concerned with the cost/affordability of adoption and only 5% were concerned with adoption disruption).

¹³⁰ Interview with G--- & L---, *supra* note 92 (discussing how their desire to adopt forced them to save up funds for quite some time knowing the financial burden that the adoption process could put on them and how they, like many looking to adopt, are well aware of that burden far before the actual adoption).

¹³¹ Interview with Goldheim, *supra* note 5 (explaining that for most domestic adoptions the expenses, or at least the ones that would be most likely to be reimbursed, are about as much as the premium for the insurance and therefore it just becomes a "pointless wash" if used).

¹³² Interview with L--- & W---, Grandparents of Adopted Child, from Manchester, Conn., in Hartford, Conn. (Nov. 21, 2014).

¹³³ See Levy, *supra* note 15, at A1 (describing the Tennessee woman who sent her seven year-old son back to Moscow with just a type-written note).

¹³⁴ Interview with L--- & W---, *supra* note 132. The grandparents clarified that when they said "child she was unsure of" that they meant a child she had not done all of the research on or could not get all of the research she wanted, like medical records, on. Apparently the child that the grandparents' daughter ended up adopting in 2012 was an infant from a state foster home and not from overseas like the daughter originally thought she would do.

scorn that Daniels believed was a critical reason for the failings of the adoption disruption insurance policy he underwrote.¹³⁵

In the United States a disrupted adoption still holds a particular stigma, one that views it as “a shameful act of abandonment and a failure on all those involved in the adoption process.”¹³⁶ Remembering the feelings of G--- and L---, when their adoption disrupted, and their unwillingness to talk about it with anyone makes more sense considering that “[f]eelings run very high and manic for many parents . . . and the reality of [losing] a very real child” is often very “crushing.”¹³⁷ Adoption is and always has been a private matter and the very idea of possibly having to disclose a lot of information about adoption to a stranger can be very daunting.¹³⁸ This holds even more truth considering the very strong stigma that the public and media has had on the issue in the past. Thus, the possibility of disclosing this information to an insurance claim handler could possibly internalize the shame.¹³⁹ Now there is no statistical data on this issue regarding the willingness to obtain an adoption insurance policy but it seems that adopting parents are indeed describing a strong desire to keep their adoptions private, especially if one were to end up with the adoption being terminated, just as Daniels described.¹⁴⁰

So maybe if the insurance companies were willing to expand their market efforts more people would flock toward these kinds of adoption disruption policies. Maybe if the disruption policies were expanded to more than just birthmother adoptions and more than just domestic adoptions then more people would be interested in not just looking up the disruption policy but actually investing in it. Or maybe if more people are educated about the realities of adoption and how “disruption may be the best thing for both the child and the adoptive parents” in that terminations of adoption are not always deserving of such a negative stigmatism,¹⁴¹ then maybe adopting parents will be more willing to open up about their

¹³⁵ Telephone Interview with Daniels, *supra* note 59.

¹³⁶ *Sisneski*, *supra* note 98.

¹³⁷ *Id.*

¹³⁸ See *supra* note 111 (describing an adoptive parent’s response to the hypothetical situation of reporting a claim of adoption disruption to an insurance claim handler)

¹³⁹ *Sisneski*, *supra* note 98 (writing that for adopting parents adoption disruption remains to be horrifying and the possibility of being considered the one to disrupt the adoption can bring about an “unspeakable shame”).

¹⁴⁰ Telephone Interview with Daniels, *supra* note 59.

¹⁴¹ *Sisneski*, *supra* note 98.

adoptions and in doing so will be able to work with insurance companies to create a policy that is more fitting to the adoption community's needs.

But looking forward there are many things that need to be done before any of these questions can be answered. For one, there needs to be more national studies on adoption disruptions and/or dissolutions by reputable government agencies, surveyors, scholars, or adoption agencies. Without statistics on what the most recent trends and facts are it is difficult to analyze whether or not the adoption market is once again able to align with insurance in establishing a stable market for an adoption policy. Second there needs to be nationwide surveys and questionnaires to specifically and directly target adopting parents on whether or not they would be not only interested in but would actually invest in something like Philadelphia Insurance Company's 2006 adoption disruption policy. Unfortunately, the survey that the National Adoption Foundation distributed and recorded did not target the actual adopters and maybe that is why the statistics received from that survey were so deceptive of the market's interest in the policy.¹⁴²

This article may be the first of its kind to explore the intersection between adoption and insurance but hopefully it is not the last. The adoption market is statistically a market that reads "compatible" with the insurance market. But for whatever reason the adoption insurance policies find themselves to be more like an enigma in their relationship to adoption than a partner with the stable market. Hopefully, one day efforts will be taken to solve this puzzle and in doing so will create a policy that encourages potential adopting couples, who are on the fence, to adopt. The basic principle behind adoption is that every child deserves a home, a loving home, and the people who give them that . . . well, those people deserve to know that society has their back and supports them in such endeavors. Insurance companies can become another support and help avail future potential adopters of their fears and in the process avail children of their fears of being family-less. Now wouldn't that be something worth striving for.

CONCLUSION

Insurance companies have the ability to create a policy that aligns perfectly with the needs and desires of society. Likewise, society has the ability to create, influence, and eliminate a market regardless of what

¹⁴² *ADI Policy*, *supra* note 68; Telephone Interview with Daniels, *supra* note 59.

statistics may indicate otherwise. In the case of adoption disruption insurance and the adoption market, all the statistics and observations the National Adoption Foundation, Rose & Kiernan, Inc., and the Philadelphia Insurance Company gathered and examined indicated that such a policy would be successful but clearly history and modern society have shown that not to be the case.

It is possible that because the adoption market relies so heavily on the human element that statistics cannot appropriately measure the market's profitability or desire in terms of creating or sustaining adoption disruption insurance. Those who are preparing to adopt seem to do the research and they seem to know what the statistics are saying about adoption before they undergo the process. Therefore, most adopting parents are already saving up for the financial commitment required to adopt children and have prepared themselves, at least, for the financial loss that might ensue upon termination of the adoption. Especially with statistics showing that pretty much all adoptions are finalized without an issue, it seems adopting parents are more willing to take the chance without the concrete safeguard of an adoption disruption insurance policy.

Regardless of the financial side of adoption, it appears that it is truly the emotional and mental effects of an adoption being disrupted that cannot be completely prepared for and cannot be remedied through an insurance plan. This combined with the still strong social stigmatism of those who have "terminated" an adoption causes those who actually face an adoption disruption not want to disclose it, let alone deal with an insurance company for possibly months or years arguing, possibly in court, whether or not their adoption disruption circumstances qualify them for financial reimbursement.

Therefore, it appears that, at least at this time to the adopting community, the private and personal aspect of adoption remains and will remain more important than the need to get financial reimbursement for fees and expenses dispersed if an adoption is disrupted. Maybe in the future when more accurate information and statistics about adoption, disruptions, dissolutions, and those processes become more readily available, the attitude of the adopting community will change. But until then, it seems adoption disruption insurance will have to wait to make use of the constant and ever-present adoption market that exists in America. However, what is certain is that adoption was, is, and will forever remain to be a BEAUTIFUL thing.

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