
NOTES

Taxing Youth: Health Care Reform Writes a Costly Prescription that Leaves the Young and Healthy Paying the Bill

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ABSTRACT

With the American health care system facing a looming crisis due to unsustainable rates of medical cost inflation, the government has reacted by passing the Patient Protection and Affordable Care Act. While the present ubiquity of third-party payers in the form of health insurance or government programs spawns inefficiencies and perverse incentives that drive market forces to work against, rather than toward, maximum social welfare, the reform bill threatens to exacerbate the very inefficiencies it seeks to avoid. Rather than focusing on controlling medical cost inflation, the bill seeks to include high-risk groups that are normally priced out of the insurance market, thus placing more stress on the payment model. The individual mandate—making health insurance mandatory—ensures that the low-risk young and healthy demographic will bear the cost of this increased burden on the insurance system. This Note examines how the recent health reform bill proposes to restructure the insurance market itself and analyzes the inadequacies of the individual mandate. Further, it briefly explores the constitutional challenges to the mandate and discusses whether the health reform bill is salvageable in light of its deficiencies.

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TABLE OF CONTENTS

I. INTRODUCTION.....	355
II. A FAILURE OF THE FREE MARKET—HOW HEALTH INSURANCE HAS SPUN OUT OF CONTROL.....	357
A. INSURER PRACTICES AND THE RESULTING MARKET FORCES	358
1. Risk Selection	358
2. Adverse Selection and the “Death Spiral”	359
B. ANOTHER PITFALL: HOW INSURANCE BENEFITS AFFECT CARE CHOICES AND CREATE MORAL HAZARD	361
C. THE BROKEN CHASSIS—EMPLOYER SPONSORED INSURANCE	362
III. RESTRUCTURING HEALTH INSURANCE MARKETS: THE PPACA’S INCLUSIONARY REFORMS NECESSITATE AN INDIVIDUAL MANDATE	364
A. PREMISE OF THE INDIVIDUAL MANDATE.....	365
1. Emphasizing Social Cohesion at the Expense of Efficiency	365
2. Cross-Subsidization: The Not-So-Hidden Costs	366
B. PPACA MANDATE—TOO WEAK TO STYMIE ADVERSE SELECTION	368
1. The Cure Becomes the Disease—Restructured Markets Foster Adverse Selection.....	369
2. Looking to Precedent—the Massachusetts Mandate	372
3. Other Weaknesses in the Individual Mandate	375
a. Numerous Exemptions, Exceptions, and Waivers	375
b. No Sanctions beyond a Tax Penalty	376
c. Tight Age Bands Give No Latitude to Attract Younger Enrollees	377
C. PREMIUM SUBSIDIES: WILL THE “CARROT” SUCCEED WHERE THE “STICK” FALLS SHORT?	378
1. Perpetuating Americans’ Disconnect from Health Care Costs Through Subsidies	378
2. Missing the Mark—Subsidies Will Not Attract the Young	380
IV. MUCH ADO ABOUT NOTHING? CONSTITUTIONAL CHALLENGE THREATENS THE MANDATE.....	382
A. COMMERCE CLAUSE CHALLENGE	382
B. ANOTHER WRINKLE—CAPITATION TAXES	385
V. MOVING FORWARD—WITH OR WITHOUT THE PPACA.....	387

A. RIGHTING THE SHIP—POTENTIAL FIXES FOR THE PPACA	389
VI. CONCLUSION	391

I. INTRODUCTION

The complex affair we call the world requires a great variety of people to keep it going.

—Charles Dudley Warner¹

By all accounts, the American health care industry currently suffers from chronic dysfunction that is perpetuated by gaping inefficiencies, perverse incentives, and market failures.² Incredibly, when compared to six other developed countries, including Australia, Canada, and the United Kingdom, the United States ranks among the lowest in quality of health care, yet spends almost twice as much per patient.³ Much of this inefficiency is driven by the third-party payer system in which health insurers or governmental safety net programs pay the vast majority of health care expenses.⁴ By insulating consumers from medical costs, the conventional wisdom of supply-and-demand economics is turned on its head, and the market falls into disrepair. Instead of targeting the true culprit in our broken health care system—unsustainable medical cost inflation—the government has traditionally chosen to perpetuate this third-party payer system.⁵ The Patient Protection and Affordable Care Act (“PPACA”)⁶ is

1. CHARLES DUDLEY WARNER, *THE GOLDEN HOUSE* 53 (1894).

2. See, e.g., M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 391–94 (2009) (“The American health care system is on the glide path toward ruin. Medical spending . . . is on track to reach 30 percent of gross domestic product (‘GDP’) a quarter century from now and half of GDP within seventy-five years.” (footnote omitted)).

3. KAREN DAVIS, CATHY SCHEON & KRISTOF STRMIKIS, THE COMMONWEALTH FUND, *MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY* 1, 2, 3 ex. 1 & 3 (2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf.

4. See J. Paul Singleton, *Can You Really Have Too Much of a Good Thing?: How Benevolent Tax Policies Have Attributed to the Explosion of Health Care Costs and How New Policies Threaten to Do More of the Same*, 8 DEPAUL BUS. & COM. L.J. 305, 313 (2010). Although the United States spends almost twice as much per patient as most other developed countries, American consumers pay fewer health care costs out-of-pocket than almost every other industrialized nation. *Id.* at 315–16 (citing CHRIS L. PETERSON & RACHEL BURTON, CONG. RESEARCH SERV., RL34175, U.S. HEALTH CARE SPENDING: COMPARISON WITH OTHER OECD COUNTRIES 36 (2007)).

5. SOC. SEC. ADVISORY BD., *THE UNSUSTAINABLE COST OF HEALTH CARE* 11 (2009), available at http://www.ssab.gov/documents/TheUnsustainableCostofHealthCare_graphics.pdf. This includes Medicare and Medicaid, not to mention the federal tax exemption for employer sponsored insurance (“ESI”), which encourages employers to funnel as much compensation through health insurance as possible, driving up medical costs. See *infra* Part II.C.

but the latest foray into a payment model that does little to correct the system's long record of inefficiency.⁷

In the lead up to the passage of the PPACA, the insurance industry played the role of scapegoat in the political rhetoric,⁸ yet in the end, insurers will be the “central actors” in the bill's implementation.⁹ Nevertheless, insurers face a dramatically overhauled regulatory regime that will strip them of their core tools for risk screening because the PPACA bans preexisting condition exclusions, annual/lifetime benefit limits, and the like.¹⁰ By eliminating insurers' ability to screen out high-risk individuals, the bill will completely restructure the health insurance market—ideally shifting the focus from competition for the lowest risks to competition based on price and quality.¹¹ Although the PPACA is highly complex and spans thousands of pages, the legislation essentially revolves around the ban on risk selection by health insurers and the individual mandate that makes the ban possible.¹²

No longer able to mitigate risk through the traditional means of risk selection, insurers will have to pass the costs of reform onto low-risk groups, effectively resulting “in a redistributive tax on youth and good health.”¹³ Under normal circumstances, young and healthy individuals would simply drop out of the market instead of paying inflated premiums to cross-subsidize their high-risk counterparts.¹⁴ Therefore, the PPACA

6. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 26 and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified at 42 U.S.C. § 1305).

7. See Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 8 (2010) (arguing that a fragmented health insurance market will “thwart” the goals of the PPACA).

8. See, e.g., Amy Goldstein & Scott Wilson, *Obama Launches Attack on Insurers: New Strategy Late in Debate Tactic Aims to Gather More Support for Health-Care Bill*, WASH. POST, Mar. 9, 2010, at A1 (characterizing the onslaught as a “near-daily demonization of the [health] insurance industry”).

9. Lucinda E. Jesson, *Health Insurance Reforms: Once in a Lifetime Change or Same as It Ever Was?*, 7 NAELA J. 125, 126 (2011).

10. *Id.*

11. David Balto, *Making Health Care Competition Work: How to Ensure Health Insurance Reform Is Transparent and Effective*, CTR. FOR AM. PROGRESS (June 25, 2010), http://www.americanprogress.org/issues/2010/06/health_competition.html.

12. See Michael Lee, Jr., *Trends in the Law: The Patient Protection and Affordable Care Act*, 11 YALE J. HEALTH POL'Y L. & ETHICS 1, 2 (2011) (discussing the ban on discrimination against preexisting conditions).

13. Theodore W. Ruger, *Can a Patient-Centered Ethos Be Other-Regarding? Ought It Be?*, 45 WAKE FOREST L. REV. 1513, 1513 (2010).

14. See Matthew R. Farley, *Challenging Supremacy: Virginia's Response to the Patient Protection and Affordable Care Act*, 45 U. RICH L. REV. 37, 50–51 (2010) (“The rationale for the

enforces the individual mandate to compel universal participation in the newly restructured health insurance market.

At its very core, the new regulatory scheme will shackle the invisible hand of the insurance market—eschewing self-interest for social solidarity while *mandating* both supply and demand. This Note explores the interdependence of heightened insurer regulation and the individual mandate, pointing out the fundamental weaknesses therein, and questions how the PPACA would “bend the cost curve”¹⁵ of rising medical inflation. Part II provides a brief background on the health insurance market and the conditions that have warranted government intervention. Part III explores the premise of the individual mandates in general and discusses the flaws and shortcomings of the PPACA’s mandate. Part IV provides a brief primer on the constitutional challenges the individual mandate faces. Part V reorients the focus to the PPACA as a whole and considers whether the bill is salvageable in light of its inherent flaws. Part VI concludes.

II. A FAILURE OF THE FREE MARKET—HOW HEALTH INSURANCE HAS SPUN OUT OF CONTROL

The private market approach to health care suffers from several deficiencies, largely because health care operates on third-party payments.¹⁶ While market-based strategies foster efficiency and value in other sectors, their application to health care often defies conventional economic wisdom.¹⁷ For instance, research and development generally cuts costs in other industries, yet investment in medical technology often increases costs.¹⁸ A far more deleterious effect is observed in the fundamental operations of supply and demand, in which Roemer’s Law dictates that “[s]upply may induce its own demand where a third party

individual mandate is simple: it is the only way to force young, healthy individuals—who often voluntarily forego health insurance coverage—to pay into the system, thereby cross-subsidizing the elderly and unhealthy.”).

15. President Obama declared that “bending the cost curve downward”—slowing the growth of medical expenditures—was a primary goal of the PPACA, yet many experts have come to the opposite conclusion, that the PPACA will only “exacerbate the same inefficiencies and perverse incentives that have led to the current situation.” Jason Fodeman & Robert A. Book, Op-Ed., “*Bending the Curve*”: *What Really Drives Health Care Spending*, WALL ST. J. (Feb. 19, 2010), <http://online.wsj.com/article/SB10001424052748703787304575075843971534082.html>.

16. David W. Johnson & Nancy M. Kane, *The U.S. Health Care System: A Product of American History and Values*, in *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 323, 332 (Einer R. Elhauge ed., 2010).

17. *See id.*

18. *Id.* *See also* Fodeman & Book, *supra* note 15 (discussing the effect of medical technology advancements on health care costs).

practically guarantees reimbursement of usage.”¹⁹ Essentially, insured patients will take advantage of their supplied benefits to achieve the maximum cost-to-benefit ratio for their policy, which fuels demand for, and overutilization of, medical resources.

A. INSURER PRACTICES AND THE RESULTING MARKET FORCES

1. Risk Selection

The most significant reform in the PPACA is the elimination of insurer risk selection—all the other reforms, including the mandate, revolve around this fundamental purpose.²⁰ Risk selection is the insurer practice of denying coverage or charging higher premiums based on risk factors such as preexisting conditions and medical or claims history.²¹ Sick or high-risk individuals are made to bear a more expensive premium that more accurately represents the costs the insurer expects to incur on the insured’s behalf.²² This is a premise of economic efficiency—it is *actuarially fair* to charge people the expected average cost of their risk pool.²³

Left unregulated, however, the system reaches a discomfoting result. Since the sick must pay higher premiums, the distribution of insurance begins to cut along the lines of health and income, and given intense medical inflation, eventually only the healthy and wealthy can afford to purchase insurance.²⁴ Society accepts this result in many other markets, but

19. *Roemer’s Law*, HEALTHCARE ECONOMIST (Oct. 16, 2006), <http://healthcare-economist.com/2006/10/12/roemers-law/>. See also *Miller Philosophical, Blunt, Calls for Systemic Change*, STANFORD SCH. OF MED. CARDIOTHORACIC SURGERY, http://ctsurgery.stanford.edu/about/news/miller_aats_speech.html (last visited Dec. 29, 2011).

20. Lee, *supra* note 12, at 2.

21. See Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. HEALTH POL. POL’Y & L. 175, 176–78 (2000) (discussing the insurer practice of grouping individuals into risk classes with varied premiums depending on expected costs associated with those classes). By the correlated phenomenon of risk segmentation, insurers do not include individuals in the same community in the same risk pool—they pool individuals on a very microeconomic scale so that premiums will closely coincide with expected losses. Risk segmentation has come to be viewed as producing several negative results, including abnormal profits, wasted resources, and inefficient limitations on coverage and services. These effects are minimized when the insurer cannot underwrite risk on a small scale, and currently, this occurs only in the large-group market. While large-group employers can pool their employees to negotiate a lower community rate, the individual- and small-group market is especially susceptible to risk segmentation. See generally Roger Feldman & Bryan Dowd, *Risk Segmentation: Goal or Problem?*, 19 J. HEALTH ECON. 499 (2000) (discussing the results of risk segmentation on the market).

22. See Nichols, *supra* note 21, at 176–77 (discussing the effects of risk pooling within a segmented risk class).

23. See *id.*

24. See *id.*

when the only way to reliably access health care is usually by having insurance, the exclusion of the poor and sick becomes problematic. Thus, in *laissez-faire*—the absence of regulation—the invisible hand of the free market seems to naturally reject the notion of maximizing societal benefit.

The PPACA seeks to correct the inaccessibility of the individual market by eliminating the insurers' tools of risk selection. Essentially, the insurer will only be able to adjust an individual's premiums based on the community rating and, to a limited extent, the age of the applicant.²⁵ Other aspects of the bill, such as guaranteed issue/renewal and a ban on lifetime/annual coverage limits, will inhibit insurers' ability to manage risk—forcing them to sell unlimited policies to the high-risk individuals that were previously priced out of the market.²⁶ Without risk selection, adverse selection can flourish, destabilizing the insurance market.²⁷

2. Adverse Selection and the “Death Spiral”

Adverse selection describes the situation in which high-risk individuals disproportionately purchase insurance because they expect the benefits of insurance to outweigh the cost of their premiums.²⁸ This is a common inefficiency in insurance markets because individuals usually have better information on the losses they will probably incur than insurers do.²⁹ For example, imagine an individual who has a clean driving record but knows that he often drives recklessly. The insurer is unaware of his penchant for dangerous driving and offers him low-premium insurance, which he will most likely accept because he knows he poses a greater risk than his record indicates. Continuing the auto insurance analogy, what

25. Insurers may apply different risk rating to large communities, but within the larger community, premiums may only vary by a factor of 3 for age, and a factor of 1.5 for tobacco use. Aside from those risk factors, premiums may *only* vary according to the value of the plan's benefits and family structure of the applicant. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1201, § 2701, 124 Stat. 119, 155–56 (2010) (to be codified at 42 U.S.C. § 300gg) (limiting the criteria by which insurance rate premiums for the individual- and small-group market may vary).

26. *See id.* sec. 1201, § 2702–2703, 124 Stat. at 156 (limiting, among other things, insurers' ability to preclude uninsured people with preexisting conditions from coverage); *id.* sec. 1001, § 2711, 124 Stat. at 131.

27. *See* Singleton, *supra* note 4, at 322–23 (discussing the elimination of risk selection without an individual mandate).

28. Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage? California's Recent Failed Experiment*, 18 S. CAL. INTERDISC. L.J. 485, 492 (2009) (“Adverse selection is the insurance phenomenon that occurs in voluntary programs when the older, sicker, and high demand population enroll in the insurance pool and younger, healthier and low demand individuals do not, thereby driving up the cost of health care and health insurance premiums and often resulting in making insurance unaffordable for the less well-off enrollees.”).

29. *See id.*

would happen if drivers with multiple DUIs could suddenly purchase auto insurance without providing a driving record? They would flock to buy insurance at reduced premiums. This is why adverse selection becomes particularly dangerous when insurers have no ability to screen risk.³⁰

Markets that allow insurers to segment risk are much more stable because they are at far less risk for this detrimental adverse selection.³¹ When the ability to screen risk is removed, high-risk individuals flood the market and increase the collective risk of the pool, so premiums must be raised to meet higher costs.³² The rising premiums eventually exceed low-risk individuals' willingness to pay, driving them from the market, leaving an ever more toxic risk pool. The resulting cycle is commonly referred to as a "death spiral."³³ Insurance risk pools need both healthy and sick enrollees to succeed, so when healthy individuals drop coverage, the pool deteriorates and insurers risk insolvency.³⁴ Even without the PPACA, insurers face death spirals with rapidly rising medical costs forcing up premiums and driving low-risk individuals to take their chances without insurance.³⁵ These insurers on the individual market were already on uneven footing before the PPACA, and the ban on risk selection will further destabilize the market.³⁶

Though the health insurance market conditions are *actuarially* fair, the government has traditionally sought to avoid a system that seems to exclude the sick and poor. This explains America's extensive safety net programs like Medicare and Medicaid for the elderly and the poor, respectively.³⁷ The cost of including all the groups within the PPACA's ambitions, however, would be staggering—and thus impossible to fund without raising taxes.³⁸ Thus, the architects of the PPACA relied on a form of "health redistribution" to sidestep raising direct taxes.³⁹

30. Insurers have some tools to combat adverse selection, such as waiting periods, and of course the PPACA's individual mandate should stymie adverse selection by compelling participation in the insurer risk pool. See *infra* Part III.B (discussing the goals of the PPACA's individual mandate).

31. Deborah J. Chollet, *Consumers, Insurers, and Market Behavior*, 25 J. HEALTH POL. POL'Y & L. 27, 37–38 (2000).

32. See Paul Krugman, Op-Ed., *California Death Spiral*, N.Y. TIMES, Feb. 19, 2010, at A27 (describing the "death spiral" phenomenon).

33. See *id.*

34. *Id.*

35. *Id.* (discussing California Anthem Blue Cross's insistence that its attempt to raise individual premiums as much as 39 percent was due to the death spiral it was facing).

36. See *id.*

37. See Nichols, *supra* note 21, at 176–78.

38. See Hoffman, *supra* note 7, at 35 (noting that subsidizing low-income uninsureds is estimated to cost eighty billion dollars per year).

39. Health redistribution, as Allison Hoffman explains, entails compelling "the healthy to finance

B. ANOTHER PITFALL: HOW INSURANCE BENEFITS AFFECT CARE CHOICES AND CREATE MORAL HAZARD

In addition to premiums, insurance benefits also play a crucial role in dictating one's health care options and choices. Notably, third-party payment compensates "reimbursable care" whether or not it is appropriate while discouraging "appropriate care" when it is unreimbursable.⁴⁰ Thus, insurance benefits packages can both encourage wasteful services while discouraging appropriate treatments.⁴¹ When there are multiple treatment options, the insured patient usually faces the same copayment regardless of their choice—any additional costs will be passed on to the insurer.⁴² This situation, in which the insured has a decreased incentive to avoid losses that are covered, creates the problem of moral hazard.⁴³

Generally, moral hazard refers to the natural human inclination to engage in immoral, risky, or inappropriate behavior because there is ultimately no negative consequence.⁴⁴ Theoretically, moral hazard manifests in health insurance in two ways: (1) benefits that cover certain preventable health risks decrease the incentive to avoid such risks;⁴⁵ and (2) excessive benefits encourage overutilization and expensive care choices because people generally will try to get the most value out of their insurance benefits, even if it means choosing a less efficient treatment option.⁴⁶ The inherent problem of moral hazard in health insurance is

care for those sicker than themselves." *Id.* at 32. "Health redistribution is normatively complex, and might concern even those who broadly support redistributive goals." *Id.* at 33. For one, health redistribution can be regressive, whereby raising concerns that the healthy poor could be subsidizing the wealthy sick. *Id.* "A second concern with health redistribution, as opposed to income redistribution, is that the weight of health redistribution lies of [sic] the shoulders of the financiers, who are likely healthy and, for the most part, young." *Id.* at 34.

40. Johnson & Kane, *supra* note 16, at 332.

41. Singleton, *supra* note 4, at 315–16. For example, if an insurance plan covers an expensive diagnostic test to rule out a highly unlikely disease, the patient will likely consent to the test because it is a covered service, even though it may be wasteful. Also, health plans may discourage appropriate treatments that the patient would much prefer if they were covered. For instance, patients with an advanced stage of diabetes may be able to save their legs with careful diet management and medical supervision, but that would be very expensive, so the insurer may only cover amputation operations. For many, their insurance benefits can have a significant impact on their life and limb. *See id.*

42. Fodeman & Book, *supra* note 15.

43. Singleton, *supra* note 4, at 314.

44. *Id.* The behavior need not be grossly inappropriate—simply leaving something to cook in the oven while running a quick errand could be a form of moral hazard if having fire casualty insurance influenced that decision.

45. For example, if one has dental insurance that covers cavities, there may be less incentive for the insured to brush and floss their teeth the recommended twice a day.

46. For example, patient A is diagnosed with chemical dependency and A's coverage will cover the following two treatment options: (1) a 30-day inpatient residential treatment program for alcohol

exacerbated when federal subsidies are introduced to the mix. Essentially, subsidies cause consumers to purchase too much coverage, and that excessive coverage leads to overutilization. This phenomenon is well documented in a federal health insurance subsidy that has been around since the World War II era—Employer Sponsored Insurance.⁴⁷

C. THE BROKEN CHASSIS—EMPLOYER SPONSORED INSURANCE

To understand how the PPACA will impact insurance markets, it is important to understand how insurance is purchased today, and in that regard, employer sponsored insurance (“ESI”) cannot be ignored. The vast majority—58.6 percent—of Americans under sixty-five receive ESI.⁴⁸ Although not a traditional “subsidy,” the federal tax exemption for ESI has had a dramatic impact on the explosion of insurance premiums.⁴⁹ Because the exemption allows ESI to be purchased with pretax dollars, the policy strongly encourages employers to funnel as much compensation through ESI as possible.⁵⁰ Insurers responded to this demand for more expensive products by shrinking deductibles and expanding plan benefits to cover

abuse that costs \$30,000 or (2) an outpatient treatment program combined with free AA meetings that costs \$5,000. Assuming both treatments are fully covered and equally effective, patient A will probably choose the inpatient treatment because the value-to-cost ratio is much higher. Even if A would prefer outpatient treatment, A still might select inpatient treatment, simply to take full advantage of A's insurance benefits. Since both treatments are equally effective and the outpatient treatment is less expensive, the outpatient treatment is the more efficient choice, so the existence of coverage benefits incentivizes a \$25,000 waste in this scenario.

47. Blaine G. Saito, Note, *The Value of Health and Wealth: Economic Theory, Administration, and Valuation Methods for Capping the Employer Sponsored Insurance Tax Exemption*, 48 HARV. J. ON LEGIS. 235, 242 (2011).

48. U.S. CENSUS BUREAU, TABLE HI05 HEALTH INSURANCE COVERAGE STATUS AND TYPE OF COVERAGE BY STATE AND AGE OF ALL PEOPLE: 2010 (2011), available at <http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm>. In contrast, the individual market—where most of the newly insured will gain coverage under the PPACA—currently only insures 7.1 percent of nonelderly Americans. *Id.*

49. A tax exemption represents loss in potential revenue that is functionally equivalent to direct spending. So, even though it is not a traditional subsidy, the tax exemption for ESI cost the government \$262.2 billion in lost revenue in 2008—overshadowing every other health care tax expenditure. Saito, *supra* note 47, at 241 (citing STAFF OF THE JOINT COMM. ON TAXATION, JCX-27-09, BACKGROUND MATERIALS FOR THE SENATE COMMITTEE ON FINANCE ROUNDTABLE ON HEALTH CARE FINANCING 2 tbl.1 (2009)).

50. Singleton, *supra* note 4, at 331. If you think about it, the employer really has nothing to do with our health insurance—the prevalence of ESI is a vestige of a post-World War II tax bill that has forever altered the health insurance market. *Id.* at 310. As a result of ESI, 58.6 percent of Americans under the age of sixty-five receive their coverage through their employers. U.S. CENSUS BUREAU, *supra* note 48. In contrast, only 7.1 percent of nonelderly Americans purchase through the individual market. *Id.*

more discretionary services, which drastically inflates premium prices.⁵¹ As a result, Americans have come to expect to share very few out-of-pocket health care expenses,⁵² and this insulation has intensified the dangers of moral hazard in health insurance markets.

Furthermore, ESI has been widely criticized as a regressive tax policy because people with higher premiums (and thus higher incomes) derive a disproportionately greater benefit compared to lower-income individuals.⁵³ Nevertheless, the PPACA largely leaves ESI and the large group market relatively unscathed. The bulk of reform is focused on the individual and small group markets, where most newly insured Americans will purchase their insurance under the PPACA.⁵⁴

51. See Singleton, *supra* note 4, at 315–18 (discussing the impact of overutilization and “increasingly inclusive” insurance on overall costs).

52. *Id.* at 315 (“In fact, citizens of the United States pay fewer out-of-pocket health care expenses than almost every other industrialized nation.”). Between 1960 and 2010, medical expenditures increased from 5.2% of gross domestic product (“GDP”) to 17.9% of GDP. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., TABLE 1: NATIONAL HEALTH EXPENDITURES AGGREGATE, PER CAPITA AMOUNTS, PERCENT DISTRIBUTION, AND AVERAGE ANNUAL PERCENT GROWTH: SELECTED CALENDAR YEAR 1960–2010 (2010), available at <http://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf>. Health care now comprises the largest sector of the economy. DANA P. GOLDMAN & ELIZABETH A. MCGLYNN, RAND CORP., U.S. HEALTH CARE: FACTS ABOUT COSTS, ACCESS, AND QUALITY iii (2005), available at http://www.rand.org/pubs/corporate_pubs/2005/RAND_CP484.1.pdf (“The United States spends approximately 15 percent of its gross domestic product on health care, making health care the largest single sector of the U.S. economy.”). The trend over the years speaks volumes—in 1970, Americans paid 39.6% of their health expenditures out-of-pocket, but by 2010, consumers shared only 13.7% of their costs. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., TABLE 6: PERSONAL HEALTH CARE EXPENDITURES AGGREGATE, PERCENT CHANGE, AND PERCENT DISTRIBUTION, BY SOURCE OF FUNDS: SELECTED CALENDAR YEARS 1970–2010 (2010), available at <http://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf>. In fact, Americans pay fewer out-of-pocket medical expenses than almost every other industrialized nation. Singleton, *supra* note 4, at 315 (citing PETERSON & BURTON, *supra* note 4, at 36).

53. See Saito, *supra* note 47, at 251–57, 269–70 (criticizing the PPACA’s lenient reforms on ESI and suggesting reforms that would be better suited to cure the inherent inefficiencies in ESI); Singleton, *supra* note 4, at 332–33 (arguing that the PPACA fails to cure the inequalities resulting from the current ESI structure).

54. See U.S. CONG. BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PPACA 18–20 (2009), available at <http://cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf> (analyzing where those not participating in employment-based coverage will source their health insurance). Also, most uninsured individuals do not have the *choice* to purchase ESI, so any reform in the large-group market will have relatively little impact on the individual mandate. The PPACA also enacts an employer mandate, which will have a much more limited effect than the individual mandate. See *id.* at 7–8 (analyzing the effect of the PPACA on “employment-based coverage”). Thus, I will generally focus on the individual market and the individual mandate for the purposes of this Note.

III. RESTRUCTURING HEALTH INSURANCE MARKETS: THE
PPACA'S INCLUSIONARY REFORMS NECESSITATE AN
INDIVIDUAL MANDATE

But for every benefit which you receive, a tax is levied.

—Ralph Waldo Emerson⁵⁵

Speaking to a joint session of Congress in 2009, President Obama outlined his three primary goals with respect to health care reform: providing more stable health insurance, achieving universal coverage, and slowing the growth of health care costs.⁵⁶ On the most basic level with respect to health insurance markets, the PPACA seeks to achieve those three goals, respectively, through (1) eliminating risk selection, (2) mandating insurance coverage, and (3) controlling premium prices through regulation. Some of the most significant provisions outlined in the massive bill aim to completely restructure the insurance market, especially in the individual and small group markets.

The potential effect on health insurers cannot be understated—the PPACA institutes significant government regulation that essentially bans the type of risk selection that has been the industry standard for decades. To restructure the insurance market, insurers will no longer be able to deny coverage based on preexisting conditions,⁵⁷ and guaranteed issuance and renewability will force insurers to offer and renew coverage to every applicant.⁵⁸ Minimizing these higher risks will be increasingly difficult as the PPACA bars limitations on annual and lifetime benefits as well.⁵⁹ With risk selection eliminated, adverse selection threatens to undermine the market;⁶⁰ so to avoid a death spiral, the PPACA mandates that all Americans attain a minimum level of coverage to coerce low-risk individuals to enter, and remain in, insurer risk pools.⁶¹ In a twist of irony, this individual mandate—the brainchild of President Obama—levies a

55. RALPH WALDO EMERSON, *ESSAYS: FIRST SERIES* 125 (Philadelphia, David McKay 1888).

56. See President Barack Obama, Address Before a Joint Session of the Congress on Health Care Reform 3 (Sept. 9, 2009), available at <http://www.gpo.gov/fdsys/pkg/DCPD-200900693/pdf/DCPD-200900693.pdf>.

57. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1101, 124 Stat. 119, 141-43 (2010) (to be codified at 42 U.S.C. § 18001).

58. *Id.* sec. 1201, §§ 2702-2703, 124 Stat. at 156 (to be codified at 42 U.S.C. § 300gg-1 to -2).

59. *Id.* sec. 1001, § 2711, 124 Stat. at 131 (to be codified at 42 U.S.C. § 300gg-11).

60. Lee, *supra* note 12, at 5-6.

61. Singleton, *supra* note 4, at 323. The individual mandate—although the most critical—is just one regulation among many that are targeted to cure the effect of eliminated risk selection on the health insurance market. Indeed, “[t]he vast majority of [the] PPACA is thus devoted to solving these created problems.” Lee, *supra* note 12, at 3.

substantial but hidden tax on the same young American adults that largely swept him into office in the 2008 election.⁶²

A. PREMISE OF THE INDIVIDUAL MANDATE

1. Emphasizing Social Cohesion at the Expense of Efficiency

The underlying theory behind the individual mandate is that it will shift the health insurance market from a focus on economic efficiency to one of *social solidarity*.⁶³ An efficiency-based market should achieve the lowest possible premiums for the lowest-risk classes; however, those with the greatest health needs and risks would likely be unable to afford coverage, disproportionately impacting the most vulnerable societal groups—the poor, the sick, and the elderly.⁶⁴ The alternative is to organize the market through social solidarity, which “is based on the principle that health care is a *right* and not just another market commodity; the highest priority of social solidarity is universal coverage.”⁶⁵ Yet, unless all citizens share the commitment to social solidarity, “coercion will be necessary.”⁶⁶ The PPACA supplies this coercion in the form of the individual mandate, which distorts efficiency since the free market would naturally exclude some individuals in *laissez-faire*. Adherents to social solidarity are “willing to trade inefficiency and coercion for universal coverage.”⁶⁷

Although it sounds like a misnomer, the fundamental purpose of the individual mandate is not to extend coverage to all. Rather, the mandate is a necessary byproduct of helping high-risk individuals access the health insurance market.⁶⁸ When social solidarity reforms such as guaranteed issue and limited risk screening are introduced, high-risk individuals enter the market disproportionately by adverse selection, and average premiums rise. Without the individual mandate, this heightened cost of health

62. Aaron Yelowitz, Opinion, *Why Would Congress Compel Young Adults to Buy Health Insurance They Don't Need?*, N.Y. DAILY NEWS, Nov. 8, 2009, <http://www.nydailynews.com/opinion/congress-compel-young-adults-buy-health-insurance-article-1.416351>.

63. See Nichols, *supra* note 21, at 178–79 (“The highest priority of social solidarity is universal coverage.”).

64. *Id.* at 178. Even when markets are organized on economic efficiency, society is still perfectly free to remedy the inequalities in distribution through social aid programs. For instance, Medicare provides aid to the elderly and severely disabled without affecting the efficiency market model. *Id.* at 178–79.

65. *Id.* at 178 (emphasis added).

66. *Id.* at 179.

67. *Id.*

68. See Channick, *supra* note 28, at 492–93 (describing the individual mandate as a tool to guard against adverse selection).

insurance would exceed low-risk individuals' willingness to pay, and they would drop out of the market.⁶⁹ The economic principle behind the individual mandate is that low-risk individuals far outnumber the high-risk ones, so premiums increase marginally for the vast majority of the pool while premiums for high-risk individuals decrease substantially. What results is health redistribution by a phenomenon known as cross-subsidization, in which the low-risk people, usually the young and healthy, are made to pay higher premiums for the sake of the older and more infirm.⁷⁰

2. Cross-Subsidization: The Not-So-Hidden Costs

Although the government has traditionally accommodated high-risk groups like the elderly and the poor through direct subsidies like Medicare and Medicaid, the PPACA-restructured health insurance market will force insurers to implement cross-subsidies amongst their customers.⁷¹ This form of shifting costs, in this case to low-risk individuals, results in “what then-Professor Richard Posner once characterized as ‘taxation by regulation.’”⁷² This is partly why proponents of social solidarity seek to accomplish so much redistribution through the insurance market itself—the absence of a political consensus for social solidarity makes it impossible to accomplish all the desired redistribution through taxes and traditional subsidies.⁷³ So, although the Congressional Budget Office (“CBO”) projects that the PPACA will actually decrease the federal deficit over the coming years,⁷⁴ much of the cost of reform will be borne by the young and healthy.⁷⁵

69. Singleton, *supra* note 4, at 322. This has been documented in several states that enacted guaranteed issue health insurance without an individual mandate. Overall, coverage rates declined and insurers dropped out of the market as the states were left with increasingly higher-risk pools paying unsustainable premiums. See Nichols, *supra* note 21, at 189 & tbl.4, 190.

70. See Hoffman, *supra* note 7, at 35.

71. See Farley, *supra* note 14, at 50–51 (describing the cross-subsidization of the elderly and unhealthy by the young and healthy).

72. James F. Blumstein, Response, *Antitrust Enforcement in the Health Care Industry: A Battleground of Competing Paradigms*, 156 U. PA. L. REV. PENNUMBRA 421, 428 (2008), <http://www.pennumbra.com/responses/04-2008/Blumstein.pdf> (citing Richard A. Posner, *Taxation By Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22, 22 (1971)).

73. Nichols, *supra* note 21, at 182.

74. Letter from Douglas W. Elmendorf, Dir., U.S. Cong. Budget Office, to John Boehner, Speaker of the House of Representatives 4 (Jan. 6, 2011), *available at* http://www.cbo.gov/ftpdocs/120xx/doc12040/01-06-PPACA_Repeal.pdf (noting that the CBO projects a decrease of \$130 billion between 2012 and 2019).

75. See Ruger, *supra* note 13, at 1513 (“[T]his mandate will effectively result in a redistributive tax on youth and good health.”). It is estimated that subsidizing coverage for those with low incomes would cost eighty billion dollars per year. See Hoffman, *supra* note 7, at 35. Garnering the political support to pass such massive direct subsidies would make reform politically impossible, so the

Government-mandated cross-subsidies have a speckled past in industry regulation.⁷⁶ In the classic examples of regulation in the transport and telecommunications industries, the government sought to maintain “socially desirable” services that would otherwise be priced out of the market in the face of growing competition.⁷⁷ In the airline industry, regulators made airliners maintain their low-density, unprofitable local routes in exchange for keeping prices high on long-haul routes.⁷⁸ The government viewed local air routes as a societal benefit that would be extinguished by free market forces in *laissez-faire*, so regulations were enacted to force airlines to cross-subsidize.⁷⁹ The PPACA offers a corollary to the airline example, where health insurers will be made to cover unprofitable high-risk consumers in exchange for the influx of low-risk individuals when the individual mandate goes into effect. Prior to airline deregulation, airlines used the rents intended for cross-subsidization on rivalry battles over quality of service,⁸⁰ which eventually became inefficient competition that did not benefit the consumer.⁸¹ Most economists agree that cross-subsidization systems like the one the government seeks to introduce in the PPACA are “expensive, function unevenly and chaotically, and fail to achieve the objectives their proponents desire.”⁸² Thus, cross-subsidization’s historical inefficiency suggests that its effect could even further destabilize health insurance markets.

government resorts to “health redistribution” policies to minimize tax-funded subsidies. *Id.*

76. To some extent, cross-subsidization is already prevalent in portions of the health care industry, created by both government regulation and free market forces. For example, due to provisions within the Reagan era Consolidated Omnibus Budget Reconciliation Act (“COBRA”), health care providers are required to provide emergency medical care to uninsured patients. 42 U.S.C. § 1395dd (2006). This sounds fair and few would want to encourage health providers to act otherwise, but the same precept would not translate to other industries. Would restaurants be expected to provide food to the impoverished and hungry? This stands as a subtle example of a health care imperative that blurs the line between privilege and right. Because, at least to some degree, health services are regarded as a right for all Americans, there is a contained acceptance for some cross-subsidization. Providing this kind of uncompensated care requires health providers to charge more to insured patients to cross-subsidize, fueling rising health care costs. Yet most Americans agree that emergency room care is a right, not a privilege, so the insured demonstrate a willingness to pay. See Dwayne A. Banks, Stephen E. Foreman & Theodore E. Keeler, *Cross-Subsidization in Hospital Care: Some Lessons from the Law and Economics of Regulation*, 9 HEALTH MATRIX 1, 1–4 (1999).

77. See *id.* at 12–15.

78. *Id.* at 13.

79. See *id.* at 13–14.

80. See George W. Douglas & James C. Miller III, *Quality Competition, Industry Equilibrium, and Efficiency in the Price-Constrained Airline Market*, 64 AM. ECON. REV. 657, 657–58 (1974).

81. Banks, Foreman & Keeler, *supra* note 76, at 14.

82. William P. Kratzke, *Tax Subsidies, Third-Party-Payments, and Cross-Subsidization: America’s Distorted Health Care Markets*, 40 U. MEM. L. REV. 279, 294 (2009).

The PPACA faces very serious challenges in applying its cross-subsidization scheme because it depends on compelling so many Americans to purchase insurance. This necessity for a large popularity base is a fundamental weakness in social solidarity. It depends upon a visionary populace who understand that they could become seriously ill tomorrow and thus be willing to pay for universal coverage today.⁸³ If many disagree with that principle, “the political consensus that creates social solidarity can break down.”⁸⁴ If one lesson can be gleaned from failed state reforms, it is that there must be a critical mass of popular support behind the goals of social solidarity, or else the enacted reform will face strong pressure for repeal.⁸⁵ Popular support for the PPACA appears to fall well short of this critical mass. In a January 2011 Gallup poll, 46% of Americans supported the PPACA’s repeal compared to only 40% who would let the bill stand.⁸⁶ Against the backdrop of widespread unpopularity, the individual mandate is set to debut in a highly disadvantageous climate in 2014.⁸⁷ This raises serious questions as to whether the individual mandate can fulfill its purpose of stabilizing the restructured insurance market and stave off an adverse-selection-fueled death spiral.

B. PPACA MANDATE—TOO WEAK TO STYMIE ADVERSE SELECTION

Although proponents of the PPACA envisioned a strong individual mandate to coerce individuals into the market, political compromise in the brokering of the bill’s passage severely weakened the penalty for going without health insurance in the final version of the PPACA.⁸⁸ As enacted, the PPACA states, “[i]f an applicable individual fails to meet the requirement of [maintaining minimal essential insurance coverage] for 1 or more months during any calendar year beginning after 2013, then, . . . there

83. See Nichols, *supra* note 21, at 178–79.

84. *Id.* at 179.

85. See *id.* at 195. One of the reasons health reform has been generally successful in Massachusetts is that it passed with “virtually universal support; there were only two dissenting votes in both houses of the legislature.” Jonathan Gruber, *Massachusetts Points the Way to Successful Health Care Reform*, 30 J. POL’Y ANALYSIS & MGMT. 184, 189 (2011).

86. Jeffery M. Jones, *In U.S., 46% Favor, 40% Oppose Repealing Healthcare Law*, GALLUP (Jan. 7, 2011), <http://www.gallup.com/poll/145496/favor-oppose-repealing-healthcare-law.aspx>.

87. See, e.g., Farley, *supra* note 14, at 51–62, 79 (detailing Virginia’s constitutional challenge of the individual mandate and noting that the mandate provoked enormous opposition).

88. See JASON GRAU & KURT GIESA, OLIVER WYMAN, IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON COSTS IN THE INDIVIDUAL AND SMALL-EMPLOYER HEALTH INSURANCE MARKETS 14 (2009), available at http://www.oliverwyman.com/media/YBS009-11-28_PPACA120309.pdf.

is hereby imposed a penalty.”⁸⁹ When the provision fully goes into effect in 2016,⁹⁰ the uninsured will be subject only to a tax penalty equal to the greater of \$750 per person or 2 percent of household income per year.⁹¹ However, the flat dollar penalty for a noncompliant individual is anticipated to cover only about 16 percent of an average premium in 2016.⁹² Generous subsidies will be available for those with income below 400% of the poverty line,⁹³ but even factoring in subsidies, the cost of insurance will generally outweigh the penalty by a significant margin for most Americans. With such weak enforcement mechanisms, the individual mandate must overcome several significant hurdles before it can compel Americans to obtain health insurance.

1. The Cure Becomes the Disease—Restructured Markets Foster Adverse Selection

As discussed above, the insurance market will be restructured to make it more accessible and allow Americans to purchase coverage regardless of their preexisting conditions.⁹⁴ Ironically, though these measures are intended to include the high-risk aging and sick, this accessibility can be exploited by the young and healthy to avoid purchasing coverage until they develop a condition and actually need it.⁹⁵ The type of penalty enforced by the individual mandate can be effective when the market is operating normally; however, the restructured market opens the door to adverse selection. For instance, many states charge an uninsured driver fee for those who do not carry auto insurance.⁹⁶ If the difference between the fee and the price of insurance is negligible, most people will opt to purchase insurance to limit their liability. The effect of the penalty, however, would be

89. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1501(b), § 5000A(b)(1), 124 Stat. 119, 244 (2010) (to be codified at 26 U.S.C. § 5000A).

90. The penalty is phased in starting in 2014 at the greater of \$95 or 0.5 percent of household income, and in 2015 at \$350 or 1 percent of household income. *Id.* sec. 1501(b), § 5000A(c), 124 Stat. at 244–45; *id.* sec. 10106, § 5000A(b)(2)(B), 124 Stat. at 909–10.

91. *Id.* There is a \$2250 cap on the flat dollar penalty, but there is no cap on the percentage of income test. *See also id.* §§ 1501, 10106, 124 Stat. at 242–49, 907–11; WILLIAM F. SWEETNAM, JR. ET AL., GROOM LAW GROUP, KEY PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 20 (2010), available at http://www.groom.com/media/publication/670_Final%20GLG%20Comprehensive%20Chart%204.21.10.pdf (stating that dependent children under the age of eighteen who are not covered will be penalized at one half the individual amount).

92. GRAU & GIESA, *supra* note 88, at 14.

93. U.S. CONG. BUDGET OFFICE, *supra* note 54, at 23–24.

94. *See supra* Part III.A.

95. *See* Singleton, *supra* note 4, at 322–23.

96. For instance, Virginia has an “uninsured motor vehicle fee” of \$500. VA. CODE ANN. § 46.2-706 (2011).

severely diminished if insurance could be purchased at will, such as immediately after an accident. But this is exactly what the PPACA allows people to do.⁹⁷ By limiting waiting periods to ninety days⁹⁸ and eliminating preexisting conditions, the PPACA allows healthy individuals to opt out of insurance until they anticipate significant medical expenses.

This phenomenon has been documented in Massachusetts, where one insurer noted that about 40 percent of individual insurance purchasers stayed covered for less than five months.⁹⁹ Yet during that short tenure, each enrollee amassed an average of about \$2400 in *monthly* medical expenses, roughly 600 percent higher than expected.¹⁰⁰ Eliminating preexisting conditions and long waiting periods essentially extends the welcome mat, leaving the insurance market open to individuals “gaming that wide open front door.”¹⁰¹ Moreover, the demographic given this option—the young and healthy—would be the most inclined to exploit such a loophole in the system,¹⁰² especially given their probable resentment against a system designed to shift the cost of high risk onto them.¹⁰³

The cost of insurance will far outweigh the uninsured penalty for the vast majority of individuals. For instance, based on a 2 percent penalty and the average premium cost of \$5800 the CBO projects for 2016,¹⁰⁴ an individual would have to earn \$232,000 annually before the penalty

97. See OLIVER WYMAN, INSURANCE REFORMS MUST INCLUDE A STRONG INDIVIDUAL MANDATE AND OTHER KEY PROVISIONS TO ENSURE AFFORDABILITY 9–10 (2009), available at http://www.oliverwyman.com/ow/pdf_files/Importance_of_Strong_Individual_Mandates_-_Public_Memo.pdf. The PPACA will not be completely defenseless to this phenomenon. “The Act includes open enrollment provisions that may provide partial protection against people entering the market on an as-needed basis. However, it will not provide full protection against people deferring elective and non-emergency procedures until after they buy insurance.” *Id.* at 9–10 n.6.

98. “Waiting periods” refer to the time that must pass before an insured’s benefits go into effect. If the insurer chooses to impose the maximum allotted waiting period of ninety days, an individual could not go uninsured until they suffer an accident and receive immediate insurance to cover the medical costs associated with the unexpected accident. However, if the person goes uninsured until they develop a more long-term condition, such as diabetes or cancer, that individual could wait out the ninety days before undergoing the costly treatments associated with these conditions, effectively beating the system.

99. Charlie Barker, *A Costly Wrinkle in the Merged Market*, THE HEALTH CARE BLOG (June 26, 2009), <http://thehealthcareblog.com/blog/2009/06/26/a-costly-wrinkle-in-the-merged-market/>.

100. *Id.*

101. *Id.*

102. Unfortunately, there are no formal studies that analyze the adverse selection effects of “gaming” the Massachusetts individual mandate. Austin Frakt, *Massachusetts Individual Mandate Gaming, Continued*, THE INCIDENTAL ECONOMIST (Apr. 5, 2010), <http://theincidentaleconomist.com/wordpress/massachusetts-individual-mandate-gaming-continued/>.

103. See *supra* Part III.A.2.

104. See U.S. CONG. BUDGET OFFICE, *supra* note 54, at 6. This is the projected average premium for a single person; the average annual premium for a family is anticipated to be \$15,200. *Id.*

matched the average price of insurance. Consider a young college graduate who is fortunate enough to be employed with a \$50,000 salary, but unfortunate in that his employer does not provide health insurance. This salary is above 400% of the federal poverty level (“FPL”),¹⁰⁵ so this hypothetical student would not qualify for any government subsidies,¹⁰⁶ meaning he must shoulder the entire weight of his insurance premium, which will probably cost *at least* \$3000 in 2016.¹⁰⁷ Alternatively, he could pay the penalty—\$1000 at that income—pocket the difference and take his chances on good health.¹⁰⁸ Considering most individuals at this age anticipate their medical expenses to consist of only an annual check-up, many young Americans should be expected to roll the dice.¹⁰⁹

As it stands, twenty-one million Americans are expected to remain uninsured when the mandate’s penalty goes fully into effect in 2016.¹¹⁰ For insurers, that represents twenty-one million liabilities that could jump into their risk pools at almost any time and quickly depart, leaving a pile of

105. In 2011, 400 percent of the FPL for a single individual was \$43,560. *See 2011 Federal Poverty Level*, FOUND. FOR HEALTH COVERAGE EDUC., http://www.coverageforall.org/pdf/FHCE_FedPovertyLevel.pdf (last visited Jan. 2, 2012).

106. The PPACA provides a great deal of subsidies for those under 400% of the FPL. This will encourage greater participation in the mandate. *See infra* Part III.C.

107. I estimated this based on the CBO’s figure of an average premium costing \$5800, combined with the PPACA’s age bands, which require insurers to maintain a 3 to 1 ratio between their highest and lowest possible premiums based on age. Thus, if the median is \$5800, insurers could charge no more than \$7800, and the lowest possible premium would be \$2900. For the purposes of this hypothetical, \$3000 is only a ballpark figure, but it is a very conservative estimate of the sort of premiums young adults will face under the PPACA. I discuss age bands more *infra* Part III.B.3.c.

108. In fact, the difference, \$2000, is even more than the price of health insurance for a young, healthy individual on the market today. CTR. FOR POLICY & RESEARCH, AMERICA’S HEALTH INS. PLANS, INDIVIDUAL HEALTH INSURANCE 2009: A COMPREHENSIVE SURVEY OF PREMIUMS, AVAILABILITY, AND BENEFITS 5 (2009), *available at* <http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf>. And considering that about one-third of these young Americans choose to forego health insurance at those prices, I expect the mandate to do precious little to bring them into the market. Kate Pickert, *Young, Invincible—and the Key to Health Reform*, TIME (Sept. 22, 2009), <http://www.time.com/time/politics/article/0,8599,1925299,00.html>.

109. J. Paul Singleton outlines a similar, yet more complex, hypothetical assuming a low-risk single adult making \$37,500 per year. He estimates a 0.1% chance of incurring \$100,000 in medical expenses, a 1% chance of incurring \$10,000, a 10% chance of incurring \$1000, and a 50% chance of incurring \$500. Multiplying and adding this risk equates to an expected monetary value of medical expenses equal to \$550. Since that salary is below 400% of the FPL, he could expect a premium subsidy of \$2125. Assuming a \$750 individual mandate penalty and a \$5800 premium price, the insurance would still cost \$3675, more than double the expected cost if the individual stayed out of the market completely and simply paid the penalty. Singleton, *supra* note 4, at 326 n.131.

110. U.S. CONG. BUDGET OFFICE, PAYMENTS OF PENALTIES FOR BEING UNINSURED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/Individual_Mandate_Penalties-04-30.pdf.

medical bills.¹¹¹ In Massachusetts, where the state individual mandate supposedly has reduced the number of uninsured to 2.6 percent, “gaming the mandate” is estimated to be a three hundred million dollar problem annually. On the other hand, the PPACA is expected to leave almost 10 percent of the population uninsured¹¹²—almost four times the figure in Massachusetts. Thus, gaming the mandate could quickly become a problem costing tens of billions of dollars annually. Truly, this form of adverse selection will be a fearsome force destabilizing future health insurance markets.

2. Looking to Precedent—the Massachusetts Mandate

Considering the fact that a significant portion of the PPACA is modeled after health reform in Massachusetts, the Bay State is ripe for comparison. Unfortunately, reliable comparisons are hard to come by in the murky world of statistics. The easiest method of measuring the success of the state-level mandate is comparing the rates of uninsured before and after the reform—Massachusetts claims that the percentage of uninsured dropped from 6.4% to 2.6%.¹¹³ However, the state began using a new method to count the uninsured between those two samples,¹¹⁴ and the U.S. Census estimates that the figure is now closer to 5.5% rather than 2.6%.¹¹⁵ Even giving Massachusetts figures the benefit of the doubt, the disparity between Massachusetts and the country as a whole is large enough to

111. Not all of the twenty-one million uninsured will be paying the penalty—some are exempted by religious views, immigration status, or hardship waivers, while still others will get a pass by not filing tax returns. In fact, only four million Americans are expected to pay the penalty in 2016. *Id.* Yet most of the twenty-one million uninsured will still be able to access the restructured insurance markets and purchase coverage when they need it, just like anyone else.

112. GRAU & GIESA, *supra* note 88, at 18 (estimating 91 percent effectiveness of the individual mandate, excluding unauthorized immigrants).

113. MASS. DIV. OF HEALTH CARE FIN. & POLICY, HEALTH CARE IN MASSACHUSETTS: KEY INDICATORS 36 (2009), available at <http://openmass.org/eohhs/docs/dhcfp/r/pubs/09/key-indicators-may-09.pdf>. This figure reflects the uninsured rates in 2006, when the reform was enacted, and in 2008, when it went fully into effect. *See id.*

114. Darshak Sanghavi, *Grand Illusion: Why Do We Pretend that an Insurance Mandate Will Help the Health Care Crisis?*, SLATE (Jan. 20, 2010), http://www.slate.com/articles/news_and_politics/prescriptions/2010/01/grand_illusion.html. On the other hand, the 2006 U.S. Census Bureau statistics reported an 11.8% non-senior uninsured rate in Massachusetts, so the mandate still cut the number of uninsured in half; however, the Massachusetts statistics claim to reduce the uninsured rate by almost two-thirds. *See* U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY (CPS): ANNUAL SOCIAL AND ECONOMIC (ASEC) SUPPLEMENT (2007), available at http://pubdb3.census.gov/macro/032007/health/h05_000.htm.

115. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY (CPS): ANNUAL SOCIAL AND ECONOMIC (ASEC) SUPPLEMENT (2009), available at http://www.census.gov/hhes/www/cpstables/032009/health/h06_000.htm.

portend significant issues when the PPACA debuts on the national stage.

Prior to enacting the mandate, Massachusetts already had one of the lowest uninsured rates in the nation—6.4%. To compare, large states like California and Texas are grappling with uninsured rates of 18.6% and 25.1%, respectively.¹¹⁶ This difference is critical because adverse selection will have greater potential to wreak havoc on the market when there are higher percentages of uninsured.¹¹⁷ Secondly, although Massachusetts generally enforces a more lenient uninsured penalty,¹¹⁸ the state offers much more extensive subsidies for lower earners to purchase insurance. The different income gradients make a direct comparison difficult, but for individuals earning less than three times the FPL,¹¹⁹ Massachusetts generally requires about half of the contribution toward insurance than will be required under the PPACA.¹²⁰ In fact, almost half of the state's residents who have gained insurance since the reform pay *no* premiums at all.¹²¹ Massachusetts's emphasis on the “carrot” (subsidies) over the “stick”

116. *See id.*

117. The higher uninsured percentage generally means that there are many more high-risk individuals outside the current market. For example, if you take the quarter of Texas's population that is uninsured and assume that 10% of them are high risks, that is 2.5% of Texas's total population that will be the first to jump into the risk pool and buy insurance. At lower rates of uninsured, the gross number of high risks entering the risk pool will be smaller relative to the entire pool, so there will be less destabilizing effects from adverse selection.

118. Compared to the “greater of \$750 and 2% of income” penalty, Massachusetts enforces an income-graded penalty that can be as low as \$228 per year and tops out at \$1212 per year for individuals over 300% of the FPL. *Find Insurance: Individuals & Families: Frequently Asked Questions*, MASS. HEALTH CONNECTOR, <https://www.mahealthconnector.org/portal/site/connector/menuitem.afc6a36a62ec1a50dbef6f47d7468a0c/?fiShown=default> (last visited Jan. 2, 2012). The Massachusetts penalty initially topped out at \$912 in 2008, but it has been rising every year. *See TIR 07-18: Individual Mandate Penalties for Tax Year 2008*, MASS. DEP'T OF REVENUE (Apr. 7, 2008), <http://www.mass.gov/dor/businesses/help-and-resources/legal-library/tirs/tirs-by-years/2007-releases/tir-07-18-individual-mandate-penalties-for.html>.

119. While Massachusetts subsidies stop at 300% of the FPL, the PPACA will offer subsidies up to 400% of the FPL; however, the effect of the subsidies between 300% and 400% is anticipated to cover less than half the cost. *See GRAU & GIESA, supra* note 88, at 14.

120. Amitabh Chandra, Jonathan Gruber & Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 *NEW ENG. J. MED.* 293, 295 (2011) (“Under Commonwealth Care, adults with incomes between 150 and 200% of the FPL were asked to contribute \$35 per month. Under the [PPACA], their monthly contribution would be \$51 to \$107. At 200 to 250% of the poverty level, the monthly contributions are \$70 in Massachusetts and \$107 to \$171 under the [PPACA]; at 250 to 300% of the poverty level, the contributions are \$105 in Massachusetts and \$171 to \$242 under the [PPACA].”).

121. *See KAISER COMM'N ON MEDICAID & THE UNINSURED, KEY FACTS: MASSACHUSETTS HEALTH CARE REFORM: THREE YEARS LATER 1* (2009), *available at* <http://www.kff.org/uninsured/upload/7777-02.pdf>. The PPACA, however, does expand enrollment in Medicaid, for which no premiums are paid, but this will not be a significant portion of the newly insured. *See U.S. CONG. BUDGET OFFICE, supra* note 54, at 18–19.

(penalties) makes it difficult to compare its health reform to the PPACA;¹²² however, it does appear that mandates have the potential to succeed in an ideally subsidized environment.¹²³

The most important difference to recognize is that the most recent Massachusetts health reform actually was an attempt to patch up a previous, ineffective attempt at reform.¹²⁴ In the previous reform, Massachusetts attempted to enact guaranteed issuance and limit preexisting conditions without an accompanying individual mandate.¹²⁵ Not surprisingly, adverse selection sent the health insurance market into a death spiral as the nongroup insurance market collapsed, leaving Massachusetts residents saddled with the highest premiums in the nation.¹²⁶ Thus, even though Massachusetts experienced lower premiums and uninsured rates following reform, much of this impact is attributed to stabilization of an out-of-control market.¹²⁷

If one lesson can be gleaned from Massachusetts, it is that phasing in the mandate penalties gradually will hurt the mandate's ability to stabilize the market. Nevertheless, this lesson seems to have been lost on the PPACA, which is phasing in penalties starting in 2014 at \$95 or 0.5 percent of household income and in 2015, \$350 or 1 percent of household income.¹²⁸ In Massachusetts, "[e]nrollees who signed up before the mandate's phase-in were nearly 4 years older, had about 45% higher health care costs, and were nearly 50% more likely to have a chronic condition

122. Another wrinkle in the comparison is the different degrees of risk selection allowed in Massachusetts and under the PPACA. While the PPACA attempts to eliminate risk segmentation in every shape and form, Massachusetts still allows insurers some latitude to design plans that will attract low-risk individuals and others that are marketed for high-risk individuals. However, tighter regulation and premium price controls in the PPACA will make premiums more expensive for the young and healthy relative to Massachusetts, so the PPACA mandate will probably be less effective at capturing that all-important demographic.

123. The PPACA subsidies are discussed in more detail in *infra* Part III.C.

124. See Gruber, *supra* note 85, at 185.

125. See *id.*

126. See *id.*; CTR. FOR POLICY & RESEARCH, AMERICA'S HEALTH INS. PLANS, INDIVIDUAL HEALTH INSURANCE: 2006–2007: A COMPREHENSIVE SURVEY OF PREMIUMS, AVAILABILITY, AND BENEFITS 1, 4 (2007), available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf (“For example, average annual premiums for single policies reported in the survey ranged from \$1,254 in Wisconsin to \$8,537 in Massachusetts.”).

127. Even the CBO concedes that average premiums are going to rise quite dramatically in the wake of reform. See U.S. CONG. BUDGET OFFICE, *supra* note 54, at 9.

128. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, secs. 1501(b), 10106, § 5000A(c), 124 Stat. 119, 244–49, 909–10 (2010) (to be codified at 26 U.S.C. § 5000A). As mentioned above, the fully effective penalty under the PPACA will be the greater of \$750 or 2 percent of an individual's taxable income. *Id.*

than those who signed up once the program was fully effective.”¹²⁹ And once the mandate became fully effective, “there was an enormous increase in the number of healthy enrollees.”¹³⁰ As mentioned above, even the fully effective PPACA penalty is anticipated to equal only 15 percent of the average premium cost for most Americans—hardly an influential factor in deciding to purchase insurance. The phase-in period makes this already-marginal penalty even less effective, so nationally there is likely to be a similar “front-loading” of less healthy enrollees as there was in Massachusetts. This will lead to greater instability in the individual insurance market between 2014 and 2016,¹³¹ with adverse selection driving up premiums during that time. Faced with these even larger premiums in 2016, it will be more difficult for the flood of healthy enrollees to materialize than it was in Massachusetts.

3. Other Weaknesses in the Individual Mandate

a. Numerous Exemptions, Exceptions, and Waivers

The CBO projects that 21 million Americans will remain uninsured despite the mandate, yet only 3.9 million Americans will pay the mandate’s penalty. That discrepancy reveals the cost recovery flaws in the PPACA.¹³² Indeed, the PPACA exempts certain religious groups and sects,¹³³ American Indians,¹³⁴ those with financial hardships,¹³⁵ authorized and unauthorized immigrants, and naturally, those who do not file a tax return.¹³⁶ Additionally, the uninsured can obtain a waiver from the mandate

129. Leighton W. Klein, *Importance of the Individual Mandate: Evidence from Massachusetts*, JOURNALIST’S RESOURCE (Jan. 18, 2011), <http://journalistsresource.org/studies/society/health/importance-of-the-individual-mandate-evidence-from-massachusetts/>.

130. *Id.*

131. The PPACA does, however, institute a reinsurance program by taxing large group insurers to raise \$25 billion over the phase-in period to provide back-up insurance for insurers on the individual market. See NAT’L ASS’N OF INS. COMMISSIONERS (NAIC), PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2009: HEALTH INSURANCE MARKET REFORMS 7 (2010), available at http://www.naic.org/documents/committees_b_Market_Reforms.pdf.

132. On the other hand, the Massachusetts mandate was able to achieve high insurance rates despite having many of the same exemptions.

133. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1411(b)(5)(A), 124 Stat. 119, 225 (2010) (to be codified at 42 U.S.C. § 18081).

134. *Id.*

135. Basically, if one’s premium would exceed 8 percent of his gross adjusted income, then U.S. Department of Health and Human Services (“HHS”) would grant a waiver from paying the penalty. NAIC, PATIENT PROTECTION AND AFFORDABLE CARE ACT: SECTION-BY-SECTION ANALYSIS 35 (2011), available at http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf.

136. The penalty is enforced on one’s tax returns, so the government cannot enforce it without a return. *See id.*

if their premiums would exceed 8 percent of their adjusted gross income—an exemption for which 25 percent of the eligible population would qualify for in the first year of reform.¹³⁷ The weakness of the mandate results in lower participation among younger individuals, an effect which is estimated to inflate average annual premium prices by about \$1500 for single coverage and \$3300 for family coverage.¹³⁸

b. No Sanctions beyond a Tax Penalty

The only enforcement mechanism allotted to the PPACA is the relatively weak tax penalty.¹³⁹ Moreover, the Internal Revenue Service has already stated that it “won’t audit you to make sure you have purchased health insurance,” though it “may withhold your tax refund if you can’t demonstrate that you are insured.”¹⁴⁰ Thus, the penalty may not be an inducement to individuals who would not otherwise be receiving a sizable tax refund. Finally, the government cannot impose criminal sanctions or liens on individuals who continue to refuse to purchase insurance, so in essence, the mandate has few teeth and not a lot of bite.¹⁴¹

137. GRAU & GIESA, *supra* note 88, at 14–15.

138. OLIVER WYMAN, *supra* note 97, at 11.

139. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1501(b), § 5000A, 124 Stat. 119, 244–49 (2010) (to be codified at 26 U.S.C. § 5000A).

140. Martin Vaughan, *IRS May Withhold Tax Refunds To Enforce Health-Care Law*, WALL ST. J. (Apr. 15, 2010), http://online.wsj.com/article/SB10001424052702304510004575186082454662468.html?mod=WSJ_latestheadlines.

141. See Singleton, *supra* note 4, at 326–27.

c. Tight Age Bands Give No Latitude to Attract Younger Enrollees

Again, the primary weakness in the PPACA's individual mandate is that it will not attract enough young and healthy individuals. The restructured insurance market implements tight age rating restrictions, which will disproportionately impact younger members. In the individual and small group markets, the PPACA lays out the only factors that may affect one's premium rate—family structure, community rating, benefits value, age, and tobacco use.¹⁴² Significantly, premiums on the latter two factors may not vary by ratios of more than 3 to 1 and 1.5 to 1, respectively.¹⁴³ Thus, even the oldest and unhealthiest chain-smoker can only be charged 3.5 times as much for his health insurance as any other individual in the community. For comparison, if insurers could screen risks at 80 percent effectiveness, the ratio of high to low premiums would be closer to 10 to 1.¹⁴⁴ Relaxing this age band would allow insurers to offer lower premiums and attract younger and healthier members to stabilize their risk pools.¹⁴⁵ In fact, relaxing the age band to a more modest 5 to 1 rating could attract 500,000 younger, healthier individuals to the market over a five year period.¹⁴⁶

No mandate will reach 100 percent effectiveness, but a greater number of enrollees will yield short- and long-term stability for the substantially reformed individual market. Younger Americans will opt out of the market because the value-to-cost ratio of purchasing health insurance is expected to average out to less than 0.48—essentially, the cost will be more than double the value for this group, even after factoring in government subsidies.¹⁴⁷ For the PPACA to be effective, the young and healthy will need to participate for insurers to be able to offset the higher risks in the pool. If the mandate fails to deliver this critical demographic, this regulation would spawn adverse selection that could literally cripple the industry.¹⁴⁸

142. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1201, § 2701, 124 Stat. 119, 155-56 (2010) (to be codified at 42 U.S.C. § 300gg).

143. *Id.*

144. Nichols, *supra* note 21, at 182 tbl.1. Even at only 20 percent effectiveness, the ratio would be 4.7 to 1. *Id.*

145. GRAU & GIESA, *supra* note 88, at 11.

146. *See id.* To compare, the value-to-cost index could be as high as 10 to 1 for subsidized lower income groups of the older and sicker members. *Id.* at 16.

147. *Id.* at 16-17.

148. Such has been the effect in states that attempted to enact guaranteed issue and limited waiting times without a mandate in place. For instance, Kentucky experienced a breakdown of its health insurance market following this reform and was inevitably forced to repeal it. *See* Nichols, *supra* note 21, at 192-94.

C. PREMIUM SUBSIDIES: WILL THE “CARROT” SUCCEED WHERE THE
“STICK” FALLS SHORT?

It would be highly regressive, even draconian, to mandate expensive insurance products that lower earners have no hope of affording on their own. Thus, to help the individual mandate gain traction and make insurance more affordable, the PPACA introduces extensive subsidies in the form of advanceable refundable tax credits available to individuals with earnings below 400% of the FPL.¹⁴⁹ Nonetheless, these subsidies may create more problems than they solve. Although lower income individuals will be afforded greater access to health care, these subsidized health plans will offer benefits that far exceed the average level of benefits on the individual market today, which is anticipated to drive average claims costs up 54 percent in the five years following reform.¹⁵⁰ Thus, the subsidies will serve to further insulate consumers from both the costs of their medical treatments *and* the cost of their insurance premiums. The situation is primed for moral hazard to operate with particular vengeance.¹⁵¹

1. Perpetuating Americans’ Disconnect from Health Care Costs Through
Subsidies

To gauge their effect, it is important to understand the extent of the subsidies and how greatly they will offset the cost of insurance for the 16.6 million Americans expected to utilize them to purchase insurance. Individuals below 133% of the FPL would automatically be enrolled in Medicaid,¹⁵² but those between 133% and 400% of the FPL will receive a tax credit toward the purchase of a qualified plan.¹⁵³ For instance, a family of three earning \$36,600, or about 200% of the FPL, would pay, at most, 6.3% of their income (\$2305) for the family insurance plan—any cost above that being subsidized by the government. A very generous subsidy,

149. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1401, § 36B, 124 Stat. 119, 213–20 (2010) (to be codified at 26 U.S.C. § 36). In 2011, 400% of the FPL for a family of four was an \$89,400 annual salary. See *2011 Federal Poverty Level*, *supra* note 105.

150. GRAU & GIESA, *supra* note 88, at 3.

151. See Clark C. Havighurst, *How the Health Care Revolution Fell Short*, L. & CONTEMP. PROBS., Autumn 2002, at 55, 78–81.

152. Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. CAL. L. REV. 859, 869 (2011). Until most provisions of the PPACA go into effect in 2014, Medicaid will continue to cover less than half of those at or below the poverty line. *Id.* The PPACA will cover substantially more, “turning Medicaid into a genuine insurance program for the poor.” *Id.*

153. See NAIC, *supra* note 131, at 8.

considering the average family plan will cost about \$15,200 in 2016.¹⁵⁴ In fact, the subsidy is estimated to cover 91% of the premium cost for those between 100 and 200% of the FPL.¹⁵⁵

The vast majority of newly insured Americans will purchase their insurance through a state-sponsored “Health Benefits Exchange” with the benefit of subsidies,¹⁵⁶ so these new plans must be certified by the HHS guidelines as a Qualified Health Plan (“QHP”), which includes the “essential benefits package.”¹⁵⁷ Required benefits are nothing new—many states routinely enact “mandated benefit laws,” such as maternity care, that all health plans in the state must cover.¹⁵⁸ The PPACA system, however, introduces mandated coverage levels on a national scale, and adjusting for the differences between state and federally mandated benefits, the “essential benefits package” alone will inflate premiums over 10 percent on average.¹⁵⁹ This minimizes consumer choice by requiring plans to provide benefits that consumers may not need or wish to purchase, which, in turn, leaves consumers with fewer options to reduce their premiums.¹⁶⁰

154. See U.S. CONG. BUDGET OFFICE, *supra* note 54, at 6.

155. GRAU & GIESA, *supra* note 88, at 14. Between 200% and 300% of the FPL, the subsidy is expected to cover 70% of the premium, and between 300% and 400%, it will cover 45% of the premium. *Id.*

156. It should be noted that all subsidized plans must be approved by the HHS as a Qualified Health Plan (“QHP”) and purchased through a state-sponsored insurance Exchange. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 2201, § 1943, 124 Stat. 119, 289–91 (2010) (to be codified at 42 U.S.C. § 1396w-3). This allows the government to maintain regulatory control over insurance plans while encouraging participation in the Exchanges, which are designed to promote competition in insurance markets by allowing consumers to easily compare and purchase plans online. The Exchanges are expected to attract insurers to offer plans by offering access to a large number of consumers, much as large groups are able to negotiate lower insurance rates in the current group market. See Balto, *supra* note 11.

157. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1333(b)(6), 124 Stat. at 206–08 (2010) (to be codified at 42 U.S.C. § 18053). The PPACA outlines the categories of coverage that must be included in every QHP—including ambulatory care, emergency services, hospitalization, prescription drugs, maternity care, mental health and substance abuse disorder services, and pediatric care, among others. *Id.* § 1302, 124 Stat. 163–68 (to be codified at 42 U.S.C. § 18022). The HHS will determine precise requirements, and can impose additional criteria. *See id.*

158. Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1364. By enacting required benefits, the state chooses what medical services should be covered by insurance, but the insurer merely incorporates the costs of the benefit into premiums, so consumers end up paying the price for these initiatives. *See id.* at 1364–71.

159. GRAU & GIESA, *supra* note 88, at 13.

160. A groundbreaking RAND Corporation study suggests that greater insurance does not translate into greater health: while participants whose medical care was only partially subsidized consumed half the medical services of those who paid zero out-of-pocket costs, this decrease in health care utilization “had no adverse effects on participants’ health.” RAND CORP., THE HEALTH INSURANCE EXPERIMENT: A CLASSIC RAND STUDY SPEAKS TO THE CURRENT HEALTH CARE REFORM

Moreover, young Americans are the most likely to prefer a less extensive benefits package in exchange for lower premiums, so the excesses of the QHPs will further deter young Americans from purchasing insurance.¹⁶¹

2. Missing the Mark—Subsidies Will Not Attract the Young

Today, young Americans have the “the highest uninsured rate of any cohort in the U.S. population: some 13 million Americans”—nearly a third of Americans aged nineteen to twenty-nine—lack coverage.¹⁶² Since paying the penalty will still be a lot cheaper than buying insurance, subsidies will have to do more to boost coverage rates in the group. However, the PPACA’s premise of health redistribution, which is designed to shift costs to the young and healthy, is inconsistent with subsidizing that group,¹⁶³ and it would be difficult to enact a subsidy based on one’s good health.¹⁶⁴ Even in Massachusetts, where the subsidies are much more generous than under the PPACA, young adults, aged nineteen to twenty-five, still account for about one-third of uninsured state residents.¹⁶⁵ Thus, within the construct of health redistribution, enrolling younger members presents a problem that cannot be cured with subsidies.¹⁶⁶

The PPACA does allow “young invincible” policies that provide only catastrophic coverage and three doctor’s visits per year; but only those

DEBATE 1, 3 (2006), available at http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf. See also Singleton, *supra* note 4, at 316–17.

161. Beyond the essential benefits, the PPACA sets relatively high minimum levels of coverage for the subsidized plans. Level of coverage is determined by the plan’s actuarial value (“AV”). For instance, if a plan’s AV equals 80%, the insurer pays, on average, 80% of the cost of covered benefits. The average AV of health plans on the individual market today is 65%, and almost a third of health plans would not meet even the minimum level (60%) of coverage necessary to receive subsidies—enrollees will have to add benefits, which will raise premiums. GRAU & GIESA, *supra* note 88, at 11–13. PPACA subsidies will pay for a large portion of a Silver plan, which offers 70% AV—well above the average on the individual market today. *Id.* The CBO estimates that this higher AV level will increase premiums 18–21% above their current levels on the individual market. U.S. CONG. BUDGET OFFICE, *supra* note 54, at 9.

162. Pickert, *supra* note 108.

163. By this I mean that it would be wholly circuitous and inefficient to model a system that shifts costs to the young and healthy, and then grant them tax credits to help pay for the increased costs. Logic suggests that subsidies should just directly target unhealthy and high-risk groups in this scenario.

164. *But see infra* Part V (discussing a tax deduction for the difference between one’s annual premium and their actual costs as a potential fix for the PPACA).

165. Pickert, *supra* note 108.

166. For the PPACA to achieve a similar rate of enrollment among the young and healthy as among the sick and unhealthy, the bill would essentially have to provide direct subsidies that would more than offset the cost of premiums; however, this would abandon the theory of health redistribution in favor of moving toward a single payer system, which is more grounded in the theory of *wealth* redistribution. See Hoffman, *supra* note 7, at 71.

under age thirty or those already exempted from the mandate by financial hardship can qualify.¹⁶⁷ To further discourage these catastrophic policies, the PPACA does not provide subsidies for them—despite the fact that they will only be offered to those with financial hardship and the young.¹⁶⁸ Thus, if one's earnings are low enough to qualify for the catastrophic policies, the PPACA's subsidies would probably pay most of the cost for a health plan anyway and that individual would already be exempted from the mandate, so these catastrophic coverage plans will mostly appeal to the young. But since these catastrophic plans operate outside insurers' traditional plan risk pool, the policy is generally assumed to have little impact on premiums in the new insurance market.¹⁶⁹

The subsidies also target the income groups where rates of uninsured are the highest, so the subsidies will likely play significantly into the decision to purchase insurance. This effect has been observed in Massachusetts, where over half of the newly insured following health reform were enrolled through subsidized insurance programs offered to residents below 300% of the poverty line.¹⁷⁰ Then again, the subsidies in Massachusetts were much more generous, requiring half the contribution that will be required under the PPACA, on average.¹⁷¹ Even though the PPACA stretches the subsidy into a higher income bracket than Massachusetts—400% FPL as opposed to 300% FPL—more than eighteen million uninsured Americans will not qualify for any subsidy.¹⁷² Young Americans, such as the hypothetical college graduate earning a \$50,000 salary,¹⁷³ will be particularly dissuaded from buying insurance by the fact that others are receiving subsidies for inflated premiums and excessive benefits that cover much more than they need. Essentially, the carrot of federal subsidies only goes so far while the stick—a weak mandate penalty—hardly goes far enough to coerce young Americans to purchase insurance.

167. GRAU & GIESA, *supra* note 88, at 13. To qualify by financial hardship, one must earn below 200% of the FPL. *Id.*

168. *See id.*

169. *See id.*

170. *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 121, at 1.

171. *See* Chandra, Gruber & McKnight, *supra* note 120, at 295.

172. GRAU & GIESA, *supra* note 88, at 15.

173. *See supra* Part III.B.1.

IV. MUCH ADO ABOUT NOTHING? CONSTITUTIONAL CHALLENGE THREATENS THE MANDATE

As Americans come to understand the consequences of the individual mandate, the PPACA is on uneven footing and increasingly under the scrutiny of the federal courts. Markedly low popular support for the mandate has spawned several constitutional challenges among various political corners.¹⁷⁴ In fact, much more effort seems to be centered on avoiding, rather than complying, with the provisions of the PPACA. Taking their cue on this hot-button issue, state legislators have scrambled to pass measures to prohibit the mandate.¹⁷⁵ This politicking, however, is more theatrics than substance, as the Supremacy Clause dictates that state law cannot supersede federal law.¹⁷⁶ The only challenge that has a feasible chance of success would be a Constitutional challenge to have the individual mandate struck down.

A. COMMERCE CLAUSE CHALLENGE

The federal government has limited powers to regulate and must be specifically empowered by the Constitution to do so.¹⁷⁷ Congress finds many, if not most, of its powers to regulate within the Commerce Clause of the U.S. Constitution.¹⁷⁸ Earlier this century, the Supreme Court granted Congress wide latitude to regulate commerce provided it had “a substantial economic effect on interstate commerce.”¹⁷⁹ This broad reading of the Commerce Clause gave Congress powerful authority to regulate; however, the Court has since stepped in to strike down laws that purported to regulate interstate activities because their impact on interstate commerce

174. See generally Email from Ken Cuccinelli II, Attorney Gen. of Va., to Cuccinelli Compass Newsletter (Feb. 10, 2011) (on file with author) (providing background information on the various state constitutional challenges to the individual mandate).

175. See James G. Hodge, Jr., Jalayne Arias & Ron Ordell, *Nationalizing Health Care Reform in a Federalist System*, 42 ARIZ. ST. L.J. 1245, 1248–56 (2011) (“Proposals . . . in forty states seek to derail or block components of federal health care reform.”).

176. See U.S. CONST. art. VI, cl. 2; Farley, *supra* note 14, at 57–58 (“Opposition laws, by operation of the Supremacy Clause of the U.S. Constitution, serve little to no legal purpose.”).

177. See, e.g., U.S. CONST. art. I, § 8, cl. 1 (enumerated powers); Timothy Stoltzfus Jost, *Can Congress Regulate “Inactivity” (and Make Americans Buy Health Insurance)?*, 364 NEW ENG. J. MED. e17(1) (2011), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1101400> (“The requirement must therefore stand or fall . . . as an exercise of the commerce power . . .”).

178. See, e.g., Ryan C. Patterson, Note, *“Are You Serious?”: Examining the Constitutionality of an Individual Mandate for Health Insurance*, 85 NOTRE DAME L. REV. 2003, 2016–17 (2010) (“The ability to regulate commerce [among the states] is the most important of Congress’s enumerated powers.”).

179. Wickard v. Filburn, 317 U.S. 111, 125 (1942).

was merely speculative.¹⁸⁰ Nevertheless, in the more recent case of *Gonzales v. Raich*, the Court backtracked somewhat by reaffirming the notion that Congress may regulate even local activity if it is “an essential part of a larger regulation of economic activity.”¹⁸¹ This could give Congress much greater authority to regulate commerce that is only loosely “interstate.”¹⁸²

The PPACA postures itself as an exercise of commerce powers, stating that the individual mandate regulates activity that is “commercial and economic in nature: economic and financial decisions about how health care is paid for, and when health insurance is purchased.”¹⁸³ Indeed, health insurers are often national companies, and the premiums that they collect arguably flow through interstate commerce.¹⁸⁴ The opposition, however, points out that the decision not to purchase health insurance amounts to mere inactivity, regardless of its impact on interstate commerce.¹⁸⁵ So, in many respects, the constitutional commerce question turns on whether the decision to forego health insurance is an “activity” or mere “inactivity.”

The argument for the PPACA is that remaining uninsured is, in fact, an activity because choosing to forego insurance is akin to the decision to self-insure.¹⁸⁶ By that logic, people decide to manage their own medical

180. See *United States v. Lopez*, 514 U.S. 549, 567 (1995) (striking down a federal law against possessing a gun in a school zone because gun possession is not “economic activity” and to conclude that it has a “substantial effect” on interstate commerce would be to “pile inference upon inference in a manner that would . . . convert congressional authority under the Commerce Clause to a general police power”). See generally *United States v. Morrison*, 529 U.S. 598 (2000) (proving that *Lopez* was not an aberration by striking down a federal law granting federal civil remedies for victims of domestic abuse).

181. *Gonzales v. Raich*, 545 U.S. 1, 36 (2005) (alteration in original) (quoting *Lopez*, 514 U.S. at 561). *Gonzales* involved federal regulation of homegrown marijuana, which was still within the sphere of the Commerce Clause because it covers “consumption of commodities for which there is an established, and lucrative, interstate market.” *Id.* at 26. See also Patterson, *supra* note 178, at 2025 (“After *Lopez* and *Morrison*, it appeared that . . . Congress’s commerce power was . . . subject to judicially enforceable limits. That appearance turned out to be a mirage after *Gonzalez v. Raich*.”); Sara Rosenbaum & Jonathan Gruber, *Buying Health Care, the Individual Mandate, and the Constitution*, 363 NEW ENG. J. MED. 401, 401 (2010) (observing that whether Congress has exceeded its power depends on whether the individual mandate “is about regulating individuals’ economic conduct or regulating their noneconomic status”).

182. See *Gonzales*, 545 U.S. at 36.

183. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(a)(2)(A), 124 Stat. 119, 243 (2010) (to be codified at 42 U.S.C. § 18091).

184. See *id.* § 1501(a)(2)(B); Farley, *supra* note 14, at 66.

185. Farley, *supra* note 14, at 166. See also Jack M. Balkin, *The Constitutionality of the Individual Mandate for Health Insurance*, 362 NEW ENG. J. MED. 482, 483 (2010) (“Critics charge that [people who do not buy insurance] are not engaged in any activity that Congress might regulate; they are simply doing nothing.”).

186. See Balkin, *supra* note 185, at 483 (arguing that foregoing insurance is an economic activity because when the uninsured self-insure “[t]hey substitute these activities for paying premiums to health

expenses without the benefit of insurance. This decision would constitute an “activity,” and the Court’s interpretation of the Commerce Clause provides the language to bring this activity under the umbrella of Congressional authority.¹⁸⁷ As discussed above, the interdependency of the PPACA’s regulatory scheme necessitates the individual mandate—without this critical piece of the puzzle, the PPACA falls apart. Thus, Congress would arguably have authority, under the Necessary and Proper Clause, to enact the individual mandate because it is an essential part of the larger regulatory scheme.¹⁸⁸

This reasoning, however, is susceptible to a number of challenges.¹⁸⁹ First, the plain language of the PPACA indicates that the individual mandate will enforce a “penalty,” not a tax.¹⁹⁰ So, “Congress acknowledged that it was penalizing inactivity, and it plainly intended to do so.”¹⁹¹ Second, there is no congressional precedent for penalizing citizens for failing to purchase goods or services.¹⁹² This fact alone makes it difficult to dismiss the constitutional challenge. Third, it would be difficult to draw a boundary for Commerce Clause power if the individual mandate is upheld.¹⁹³ If one’s failure to purchase insurance is deemed interstate commerce, “it is hard to fathom acts of omission that could not be tied to

insurance companies”).

187. See Jost, *supra* note 177, at e17(1)–(2).

188. See *id.* This is the justification underlying the Court’s decision in *Gonzales*. Farley, *supra* note 14, at 66–67.

189. Farley, *supra* note 14, at 67.

190. *Id.*; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1501(b), § 5000A, 124 Stat. 244–49 (2010) (to be codified at 26 U.S.C. § 5000A).

191. Farley, *supra* note 14, at 67. *But see* David Orentlicher, *Can Congress Make You Buy Broccoli? And Why It Really Doesn’t Matter*, 84 S. CAL. L. REV. POSTSCRIPT 9, 12 (2011), http://lawweb.usc.edu/why/students/orgs/lawreview/documents/SCalPostscript84_Orentlicher.pdf.

Orentlicher makes a compelling argument dismissing the activity-inactivity distinction as illusory: [T]he activity-inactivity distinction merely *correlates* with the distinction between unacceptable and acceptable behavior. It does not *define* the line between the unacceptable and the acceptable. At times, inactivity is just as problematic as activity. As Justice Antonin Scalia has written, “It would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide; or that one may not intentionally lock oneself into a cold storage locker, but may refrain from coming indoors when the temperature drops below freezing.”

Id. (quoting *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 296 (1990) (Scalia, J., concurring)).

192. Farley, *supra* note 14, at 67. *Contra* Orentlicher, *supra* note 191, at 13 (arguing that Congress often requires us to purchase commercial goods). Orentlicher argues that

[t]he U.S. Department of Transportation requires you to buy seat belts, air bags and a catalytic converter when you purchase a car . . . The U.S. Department of Housing and Urban Development requires you to buy smoke alarms when you purchase a mobile home. In all of these cases, the federal government requires you to buy something you might not want to buy by connecting it with the purchase of something you do want to buy.

Id.

193. Farley, *supra* note 14, at 67.

other national deficiencies and thus be subject to federal regulation.”¹⁹⁴

B. ANOTHER WRINKLE—CAPITATION TAXES

Several challenges to the PPACA have also accused the bill of violating to Constitution’s prohibition on certain forms of capitation tax.¹⁹⁵ A capitation tax is “levied by the government upon a person at a fixed rate regardless of income or worth,” and is commonly referred to as a “head tax.”¹⁹⁶ While Congress has wide latitude to tax income and commerce, its ability to levy direct taxes on individuals at a fixed rate is more restricted.¹⁹⁷ Essentially, capitation taxes must be apportioned evenly among the states according to the census.¹⁹⁸ Under the PPACA, if one state has a higher rate of uninsured citizens following reform, the citizens of that state will pay a higher penalty per capita than a state with a lower uninsured rate. Thus, assuming the individual mandate is a capitation tax, the tax would be unevenly apportioned among the states and in violation of the Constitution.

Again, this argument will likely turn on the distinction between “activity” and “inactivity.” If the individual mandate penalty is a tax on “activity,” Congress has greater authority and can levy an excise tax, which does not have to be evenly apportioned among the states.¹⁹⁹ Like so many statutory challenges—the validity of the individual mandate will likely turn on the interpretation of only one or two words—“activity” or “inactivity” and “tax” or “penalty.”²⁰⁰ Though the Supreme Court has recently moved

194. *Id.*

195. See, e.g., Complaint at 4, Florida *ex rel.* Bondi v. U.S. Dep’t of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla.) (No. 3:10-cv-91), 2010 WL 1038209 at *3 (“In addition, the tax penalty required under the Act, which must be paid by uninsured citizens and residents, constitutes an unlawful capitation or direct tax, in violation . . . of the Constitution of the United States.”), *aff’d in part, rev’d in part sub nom.* Florida *ex rel.* Attorney Gen. v. U.S. Dep’t of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011).

196. *Capitation Tax*, THE FREE DICTIONARY, <http://legal-dictionary.thefreedictionary.com/Capitation+tax> (last visited Jan. 4, 2012).

197. Compare U.S. CONST. amend. XVI (“The Congress shall have power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several states . . .”), with *id.* art. I, § 9, cl. 4 (“No Capitation, or other direct, Tax shall be laid unless in Proportion to the Census or Enumeration herein before directed to be taken.”).

198. U.S. CONST. art. I, § 9, cl. 4.

199. U.S. CONST. art. I, § 8, cl. 1.

200. See John S. Baker, Jr., “Not a Tax” Comes Back to Haunt ObamaCare, HEALTH CARE LAWSUITS (Oct. 15, 2010), <http://www.healthcarelawsuits.org/blog/detail.php?c=2390085&t=%22Not-a-Tax%22-Comes-Back-to-Haunt-ObamaCare> (observing that if the individual mandate is a tax, federal courts have no jurisdiction to hear constitutional challenges to it).

toward a more lenient interpretation of the Commerce Clause,²⁰¹ the individual mandate poses some difficult questions with few answers in the case law. Regardless of the outcome, challenges to the PPACA may remain pending even after 2014,²⁰² when most of the regulations are set to take effect. By then, the health insurance industry will have made substantial changes to comply with the restructured insurance market, which cannot function without the mandate.

The fervent litigation challenging the PPACA has already forged a circuit split in the federal courts of appeals. Although the Sixth Circuit initially upheld the law as constitutional in a 2-1 decision, the Eleventh Circuit struck down the individual mandate as unconstitutional a mere two months later.²⁰³ The Supreme Court has agreed to hear the case in March 2012 and is expected to render a decision by June.²⁰⁴ Unless the Supreme Court dismisses the case for lack of standing until a citizen pays the penalty,²⁰⁵ the constitutional question should be definitively answered in 2012.

Although the Court will issue a ruling on the PPACA in June, the fate of the bill may be completely settled in November following the presidential election. With Republicans making PPACA repeal one of their signature issues this election year, it is certain that the majority of the PPACA will not survive long past Obama's presidency if he is denied a second term. The dual threat of constitutional and Republican challenge to the PPACA has led many states to suspend their implementation efforts until one or both of those questions are resolved.²⁰⁶ With many states moving too slowly to meet PPACA deadlines and others flatly refusing to make changes until the Court makes its ruling, there is a significant chance that these delays will result in a messy implementation if the PPACA

201. See *Gonzales v. Raich*, 545 U.S. 1, 2 (2005) (holding that the Commerce Clause extends to the local cultivation and use of marijuana).

202. See Lyle Denniston, *Faster Health Care Appeal Asked*, SCOTUSBLOG (Mar. 11, 2011, 1:12 PM), <http://www.scotusblog.com/2011/03/faster-health-care-appeal-asked/>.

203. See *Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 533–34 (6th Cir. 2011); David G. Savage, *Healthcare Law Fight Moves Closer to Supreme Court*, L.A. TIMES, Sept. 29, 2011, at A9.

204. M. Daria Niewenhous & Brian J. Platton, *U.S. Supreme Court to Hear Arguments in ACA Cases*, MONDAQ (Jan. 3, 2012), <http://www.mondaq.com/unitedstates/x/159172/Healthcare/US+Supreme+Court+to+Hear+Arguments+in+ACA+Cases>.

205. The earliest a citizen will pay a penalty is 2015, and arguably only then will there be standing to sue. A Fourth Circuit case challenging the PPACA was thrown out in Virginia based on this argument. See *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253, 268–69 (4th Cir. 2011).

206. See Jason Millman, *On Health Reform, the Election Will Matter More than SCOTUS*, POLITICO (Jan. 13, 2012), http://www.politico.com/news/stories/0112/71425_Page2.html.

survives all its challenges.²⁰⁷ If either of the challenges to the PPACA finds their mark, the road toward repeal would be fraught with difficulties as well. Consider a Supreme Court ruling that strikes down only the individual mandate. The right-leaning Congress in 2012 is highly unlikely to enact an alternate funding mechanism to replace the mandate, so the majority of PPACA reform would likely be repealed in the wake of a stricken mandate.²⁰⁸ If a Republican wins the presidency, he will face challenges to repeal without a filibuster-proof majority. Moreover, he may have to grapple with the public backlash against some of the PPACA's more popular provisions, such as guaranteed issue.²⁰⁹

All things considered, the PPACA appears to lie between a rock and a hard place. Many states have delayed adoption of PPACA-mandated reforms because of the public outcry against the bill, and these delays threaten to further complicate implementation even if the bill manages to survive. On the other hand, constitutional and electoral challenges threaten to initiate a lengthy repeal process that would only further embroil the nation's capital in partisan bickering. Either way, the PPACA faces a bleak future.

V. MOVING FORWARD—WITH OR WITHOUT THE PPACA

Although it is universally understood among health economists that reforming American health care is essential, the foundation of the PPACA has many cracks. For one, “[w]e cannot have health care that is both accessible and affordable while insulating consumers from the cost.”²¹⁰ Instead of focusing on the core problem—rising medical expenses that outstrip wage growth year after year—the PPACA concentrates on health redistribution and cost insulation with the paternalistic individual mandate and subsidies to support it. Yet, in shifting the insurance market from efficiency to social solidarity in the face of massive unpopularity, the PPACA threatens to “exacerbate the same inefficiencies and perverse incentives that have led to the current situation.”²¹¹

207. Cecilia Vega, *White House Says States on the Way to Health Care Reform*, ABCNEWS (Jan. 18, 2012), <http://abcnews.go.com/blogs/politics/2012/01/white-house-says-states-on-the-way-to-health-care-reform/>.

208. See, e.g., Farley, *supra* note 14, at 79 (arguing that judicial invalidation presents a greater danger to the individual mandate than legislative repeal based on the current and foreseeable political climate).

209. Millman, *supra* note 206.

210. ARNOLD KLING, *CRISIS OF ABUNDANCE: RETHINKING HOW WE PAY FOR HEALTH CARE* 45 (2006).

211. Fodeman & Book, *supra* note 15 (arguing that the PPACA, by misunderstanding “the basic

America already has an enormously expensive and regressive health insurance tax initiative—ESI.²¹² By exempting *all* income that is received in the form of health insurance, employees with the most expensive plans (and thus the largest incomes) benefit the most from this tax policy.²¹³ But the PPACA leaves this segment of the insurance market—the largest segment by far—relatively unscathed by regulation.²¹⁴ Instead, the PPACA seeks to introduce yet another inefficiency-promoting tax scheme by forcing low-risk groups to cross-subsidize the high-risk ones—a “taxation by regulation.”²¹⁵ The regressive nature of this scheme is partially hidden by large federal premium subsidies, but at its core, it is still a regressive tax on health. The healthy individual earning \$50,000 in 2016 is going to pay the same inflated price for his premium as a same-aged individual earning \$1 million.

The government could achieve the same goal—insuring the high-risk—by offering them Medicaid coverage or directly subsidizing their premiums, but that would involve universally raising taxes, something that few politicians are prepared to champion. In fact, in the recent debate over federal deficit reduction, Congress seems far more inclined to cut health spending, which will force health care providers to find the money elsewhere, a move that will only drive private health insurance premiums higher.²¹⁶

So, the PPACA introduces a complicated insurance market restructuring and individual mandate that has sent shockwaves through the industry.²¹⁷ Many people who are currently insured on the individual

factors driving health care spending upward,” will lead to even higher costs).

212. See Singleton, *supra* note 4, at 310–12 (observing that the tax exclusions available for ESI offers the greatest benefit to employees in the highest income tax brackets, and that this tax sheltering opportunity likely costs the government nearly \$250 billion annually).

213. *Id.* at 310.

214. The PPACA, however, does enact the “Cadillac Tax” to tax high-premium plans, but this method of capping ESI has many issues of its own. For a great discussion on the inefficiency of the Cadillac Tax, see Saito, *supra* note 47, at 251–57.

215. See Blumstein, *supra* note 72, at 428; Richard A. Posner, *Taxation By Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22, 22 (1971).

216. Kelly Kennedy, *Debt Talks May Affect Premiums*, USA TODAY, Sept. 28, 2011, at 1B (noting that efforts to reduce the federal deficit by cutting health care spending will likely increase health insurance premiums, which already rose 9 percent between 2010 and 2011).

217. The uncertainty surrounding future market conditions has sparked massive consolidation within the health care industry. John I. Allen, *What Do You Think of Obamacare Now?*, AM. GASTROENTEROLOGICAL ASS’N, <http://www.gastro.org/mobiletools/policy-updates/734> (last visited Jan. 26, 2012) (“At a regional level, we are witnessing rapid consolidation of health care into hospital-centric health-care systems, all in anticipation of fundamental changes in reimbursement.”). And insurers are spending millions of dollars to comply with the reforms. Matthew Sturdevant, *Insurers Spend Millions to Comply with Reform*, HARTFORD COURANT (Sept. 23, 2010),

market will have to buy more coverage to meet the mandate requirements, and still more will find that their premiums have increased quite substantially.²¹⁸ Uncertainties as to the mandate's effectiveness to coerce healthy individuals into the market are compounded by a multiyear phase-in period that stretches until 2016.²¹⁹ Indeed, the insurers will experience significant short-term instability as they wait for the PPACA to go fully into effect.²²⁰

A. RIGHTING THE SHIP—POTENTIAL FIXES FOR THE PPACA

Although the bill is flawed, if President Obama manages to preserve his hallmark health care reform bill, there are some revisions that could make the reform more tenable in the long run. As seen countless times in state reform, if the government is going to restructure the health care market, only going halfway will be met with disaster. If the PPACA withstands the challenges it faces, politicians will have to stomach their distaste for the bill and strengthen some of its more unpopular measures to give it a chance to succeed.

First, the penalty for remaining uninsured and violating the individual mandate would have to be increased to make it effective. As currently written, the PPACA prescribes a marginal penalty for failing to purchase coverage in light of the staggering cost of insurance. For young and healthy Americans, the cost of insurance will outweigh its benefit by a wide margin, and the easiest way to close this gap is to increase the penalty.

Although an effort to increase the vastly unpopular penalty would likely be met with fierce opposition, eliminating the penalty phase-in period would be a much easier pill to swallow. As discussed above, the phase-in period creates a situation in which the low-risk insurance consumers prefer to purchase coverage and join the insurer risk pool only

http://articles.courant.com/2010-09-23/health/hc-insurers-reform-0924-20100923_1_health-insurers-cigna-cheryl-randolph.

218. GRAU & GIESA, *supra* note 88, at 12. Due to the Essential Benefits Package and the minimum AV of health plans for the mandate, the Grau and Giesa report estimates that “5.4 million people currently insured in the individual market (approximately 32% of the total individual market) have policies that do not meet the 60% threshold and would have to purchase higher-cost plans as a result of this requirement.” *Id.*

219. *See supra* Part III.B.2.

220. In addition to consolidation, insurers are already attempting to raise premiums before the PPACA goes into effect because they expect liquidity shortages when the increased number of claims begin to roll in. *See* Editorial, *Insurers Aren't Playing Fair*, THE INQUIRER (Oct. 2, 2011), http://articles.philly.com/2011-10-02/news/30235333_1_premium-hikes-health-insurers-rate-hikes.

after the penalty is fully in effect.²²¹ On the other hand, high-risk individuals join immediately to take advantage of reform. What results is a more toxic risk pool over the phase-in period, which drives up the cost of premiums, and by the time low-risk individuals are ready to purchase coverage, these high premiums have already priced many of them out of the market. Thus, simply eliminating the phase-in period would provide more stability to the risk pools and reduce the elasticity of premium prices over the short-term.

Second, for the PPACA to persevere, the government would have to offer more generous subsidies to ensure that the penalty does not unfairly burden Americans and attracts more consumers to the insurance market. Ideally, this subsidization would target the young and healthy Americans on which the stability of insurer risk pools depend. Perhaps the government could allow an above-the-line tax deduction for the difference between one's premium and his actual medical costs for that year. For instance, if a hypothetical insurance consumer did not utilize any medical services and spent only \$100 on prescription medication in the year, and his premium was \$3000, he could get a portion of the \$2900 difference back for maintaining good health for the year. This system could mitigate some of the moral hazard problem by minimizing overutilization, and preventative care could be exempted to ensure that the deduction would not incentivize people to avoid necessary medical care. The notion that you could recover a portion of your health insurance premiums would certainly attract more young and healthy Americans, who rarely expect their medical costs to exceed the cost of their premium.

Third, a simpler way to make the individual mandate more effective would be to widen the age bands that restrict the premium prices insurers are allowed to charge. Under the currently enacted PPACA, an insurer's premiums may only vary by a factor of three based on age.²²² Thus, the youngest members of an insurance group must pay at least one third of the premium of the oldest members in the group. It is estimated that widening the age band to a factor of five would attract another half million young Americans to purchase health insurance.²²³ Such a change would loosen the government's regulatory grip on insurers and allow them to engage in a more actuarially fair form of risk selection.

221. See *supra* Part III.B.3.c.

222. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1201, § 2701(a)(1)(A)(iii), 124 Stat. 119, 155 (2010) (to be codified at 42 U.S.C. § 300gg).

223. See GRAU & GIESA, *supra* note 88, at 11 (arguing that compared to a 5 to 1 rating, a 3 to 1 rating will "cause an additional 500,000 younger, healthier members to exist the market").

Although insurers are guilty of some degree of corruption, their well-publicized abuses have been blown out of proportion.²²⁴ The insurers' fundamental business practice—selecting and managing risk—is not driving medical costs out of control. Politicians take delight in vilifying insurers, and PPACA backers justify the insurance market restructuring as a necessary response to a failed market, but corrupt insurer practices are a very small portion of the reason why health care is so inaccessible.²²⁵ Bill Sage captures it clearly with the epigram, “It’s the delivery system, stupid.”²²⁶ Medical costs originate at the provider level, where, unsurprisingly, insurers have limited latitude to affect the price of medical services.²²⁷

In the end, the PPACA constitutes an uncomfortable confluence of social goals and industry reform. Supporters boast of the increased coverage, but the coverage comes at a high price, which will be paid by healthy and low-risk individuals. In mixing social objectives and free market reform, the PPACA threatens to push the insurance industry into a death spiral. Jason Fodeman and Robert Book put it best:

Despite the rampant inefficiencies and extremely high costs of health care in the United States, it is still possible to make the American health care system even more inefficient and more costly. Regrettably, the [PPACA] would do precisely that by saddling an already burdened system with more mandates, higher taxes, and less flexibility.²²⁸

Although the goals of the PPACA are noble, the ends do not justify the means. If the goal is to enhance accessibility for the highest risks, the government should subsidize that coverage directly instead of introducing inefficient cross-subsidization and complicated market restructuring schemes that threaten to further destabilize the entire system.

VI. CONCLUSION

In sum, the individual mandate embodies the heart of a regressive

224. See Jesson, *supra* note 9, at 125–26 (arguing that health insurers were simultaneously cast as the “villain” and the “central actors in [the] implementation” of the PPACA).

225. See Johnson & Kane, *supra* note 16, at 330–36.

226. William M. Sage, *Legislating Delivery System Reform: A 30,000-Foot View of the 800-Pound Gorilla*, 26 HEALTH AFF. 1553, 1553 (2007). Sage pokes fun at Bill Clinton’s campaign slogan, “It’s the economy, stupid,” while noting that the architects of Clinton Health (the predecessor to ObamaCare) failed to encourage a change in health delivery. *Id.* Others have noted that “it’s the prices, stupid.” Gerard F. Anderson et al., *It’s the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 89 (2003).

227. See Sage, *supra* note 226, at 1554.

228. Fodeman & Book, *supra* note 15.

“health redistribution” initiative that threatens to mutate health insurance markets into an even more unwieldy beast. Though economic efficiency and the free market approach have not yielded the ideal health care environment, the insurance market should not be so easily dismissed as a failure of capitalism. The government has the freedom to supplement the free market with programs to meet social goals; however, restructuring the market with an invasive regulatory scheme that only shifts costs toward the young and healthy will do nothing to “bend the cost curve” of rising medical inflation. In essence, Congress hopes that reforming health care will be like playing the shell game—shift around the costs enough and hopefully they will disappear by some smoky sleight of hand.

At the core of social solidarity is the principle that a substantial majority of the population must be willing to submit to its goal—universal coverage. If many citizens disagree with that principle, the cost of coercing them into the system will be far too great to sustain a lasting reform. The PPACA, particularly the individual mandate, has come under fire on all sides. Growing unpopularity, constitutional challenges, and reluctant state legislatures all indicate a growing repulsion to the individual mandate’s coercive nature. Congress utilized the premise of social solidarity to avoid massive spending and higher taxes for reform, but the inefficiency and unfairness of coercing a largely unwilling demographic to finance Congress’s reform could sound the death knell for the entire PPACA.

If the individual mandate fails, so goes the rest of the PPACA’s reform. And the substantial difficulty of enforcing such a weak mandate inspires little confidence regarding the PPACA’s future potential. Though the health care industry is ripe for reform, the PPACA takes the wrong approach by making insurance the key to reform. This foundation—the third-party payer system—is riddled with inefficiency that cannot be cured by throwing the market into a regulatory straightjacket. Compounded with the inherent inefficiencies in government-mandated cross-subsidization, the PPACA has the potential to irreparably damage the health insurance market.

Whether it is an infringement of liberty, a betrayal of capitalism, or just plain poor policy, the individual mandate lacks theoretical support within the American ethos. The mandate is not even borne of the benign goal of universal health coverage—its primary purpose is to fund a solidarity-promoting reform that would otherwise be made impossible by spending limitations. As such, the burden falls to the young and healthy in a regressive scheme that dispenses more injustice than it corrects.

