

Sick and (Still) Broke: Why the Affordable Care Act Won't End Medical Bankruptcy

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In the time it takes to read this page, another person has declared bankruptcy because of medical debt.¹ She² was likely in her mid-forties, with children, and owned a home.³ Perhaps illogically, she almost certainly had health insurance when she fell ill.⁴ She or her spouse had a job and, while not rich, she was likely in the working or middle-class.⁵ Yet, when she filed for bankruptcy her net worth was more than \$44,000 in the red.⁶

That is the face of the 2.8 to 3.3 million individuals affected by medical-expense-caused bankruptcy each year.⁷ While researchers can paint a profile of those who suffer from medical bankruptcy, its causes are as numerous as they are elusive. A constellation of factors is frequently cited: out-of-pocket medical expenses, lost income during illness, loss of medical coverage, underinsurance or no

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1. In 2007, an American family filed for an illness-related bankruptcy every 90 seconds. See David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 744 (2009) [hereinafter Himmelstein, 2009].

2. The majority of medical-expense-caused bankruptcies are filed by women. *Id.* at 743.

3. *Id.*

4. Of bankruptcy filers whose illness contributed to bankruptcy, 77.9% were insured at the onset of the illness. *Id.* at 744.

5. *Id.* at 743.

6. *Id.*

7. Himmelstein estimated that by 2007 medical bankruptcies had increased 50% from an earlier study of bankruptcies in which he reported that 1.9 to 2.2 million filers and dependents were affected by a medical bankruptcy in 2001. See David U. Himmelstein et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, 2 HEALTH AFFAIRS. W5-63, W5-67 (2005) [hereinafter Himmelstein, 2005]; Himmelstein, 2009, *supra* note 1, at 744.

insurance, and the pile-up of bills from using credit cards to pay for medical expenses.⁸

In part to protect citizens from being saddled with medical debt, President Barack Obama championed comprehensive health care reform, culminating in the passage of the Patient Protection and Affordable Care Act (“Affordable Care Act”).⁹ The Act’s main tenet is to expand access to health care by providing citizens with subsidies to pay premiums and out-of-pocket expenses.¹⁰ Under the reform measure, individuals are required to obtain health insurance, which continues to be sold by private insurers, but all new plans will be required to provide minimum benefit packages and cap out-of-pocket expenses.¹¹ Yet, little is known about what effect, if any, the Affordable Care Act will have on medical bankruptcy. President Obama insisted that the proposed reforms were necessary, in part, to protect citizens from the spiraling costs of medical care which would, arguably, reduce the number of bankruptcies. But will they?

The answer lies with the nation’s private health insurance industry. Today, insurers are increasingly looking to consumer-choice health plans, rather than the tight administrative controls of managed care, to deal with the rising costs of medical care.¹² In a consumer-choice plan, patients are given greater control over their care but are responsible for higher deductibles and other onerous out-of-pocket expenses.¹³ Advocates of consumer-choice plans believe that the infusion of individual choice will be more effective at stemming rising health care costs than the prevailing administrative controls of managed care.¹⁴ Even if true, such a move leaves families stricken by illness or injury on the hook for thousands of dollars in out-of-pocket expenses.¹⁵

The Affordable Care Act caps some of these expenses and subsidizes the cost of acquiring insurance, but it will not provide

8. See Himmelstein, 2005, *supra* note 7.

9. See *infra* notes 106, 108 and accompanying text.

10. See *infra* notes 114–20 and accompanying text.

11. See *infra* notes 112–13, 123–26.

12. See *infra* note 76 and accompanying text.

13. See *infra* notes 77–81 and accompanying text.

14. See *infra* note 80 and accompanying text.

15. See *infra* note 92 and accompanying text.

complete shelter from the financial liability of a privatized consumer-driven health care system.¹⁶ Indeed, the Affordable Care Act, by moving 32 million previously uninsured and potentially lower-income individuals into the marketplace, may actually accelerate the industry's move toward consumer-choice health plans.¹⁷ In effect, by eschewing comprehensive, single-payer universal health insurance and leaving virtually untouched the fundamental structure of our country's private health insurance industry,¹⁸ the Affordable Care Act has guaranteed that even medically insured individuals will continue to be on the hook for thousands of dollars of medical expenses.¹⁹

In light of this, the question that ought to demand our attention, and the question that this Note attempts to answer, is not whether the Act will eliminate medical bankruptcy but rather, should it? Stated differently, because the Affordable Care Act maintained the market-based approach that is the hallmark of our current health finance industry, are we better off with some medical bankruptcies than none at all? I argue that bankruptcy is a fundamental, if unsatisfying, component of a medical finance system that relies on market-based principles to reduce costs. While the Affordable Care Act will reduce the overall number of bankruptcies, and arguably eliminate the most morally objectionable causes of medical bankruptcy, in a system based on market principles there will—and must—be consumers whose own bad choices spell financial trouble. For society to “win” and receive the benefits of a consumer-driven system, there must be some who “lose.”

In Part I of this Note, I begin with an examination of medical bankruptcy in America and analyze the factors and variety of medical expenses that cause an individual or family to file for bankruptcy. Part II briefly outlines the country's private health insurance industry and how variations in health coverage schemes affect a consumer's financial liability. I note that in the years leading up to the Affordable

16. *See infra* note 126 and accompanying text.

17. *See infra* note 112 and accompanying text.

18. *See infra* note 105 and accompanying text.

19. *See infra* notes 171–72. I take no position on the wisdom of the Affordable Care Act or the variety of alternative health care reform proposals considered by Congress. Rather, this Note focuses on the effect that the Affordable Care Act, as enacted, will have on medical bankruptcy and the health insurance industry.

Care Act, insurers have increasingly injected market-based principles into health coverage thereby shifting greater financial liability onto consumers. In Part III, I turn to the recently enacted Affordable Care Act, focusing on the two primary ways that it seeks to improve the affordability of health insurance for consumers: (1) subsidies that reduce premium payments and out-of-pocket expenses and (2) strong regulations of all new health insurance plans.

In Part IV, I analyze whether and to what extent the Affordable Care Act will affect medical bankruptcy, arguing that while the Act shelters citizens from catastrophic medical expenses—protection that will reduce the overall number of debtors—it will not completely eliminate medical bankruptcy. Instead, I suggest that the Affordable Care Act will accelerate the use of deductibles and out-of-pocket expenses to reduce rising medical costs. Because these market-based tools require that consumers be penalized for their poor financial and health decisions, a limited number of bankruptcies should be expected. The measure of the Affordable Care Act's success, therefore, should be measured by its ability to improve the affordability of care and not whether it completely eliminates medical bankruptcy.

I. MEDICAL BANKRUPTCY IN AMERICA

The costs of medical care and the number of bankruptcies attributable to illness are on the rise, with bankruptcies increasing 50% from 2001 to 2007.²⁰ In fact, over 62% of all individual bankruptcy filings in 2007 were traceable to a medical event,²¹ either directly through reported medical expenditures or indirectly by financial circumstances created by a medical condition.²² The poor

20. See Himmelstein, 2009, *supra* note 1, at 744. The authors compared results of their 2007 study to a similar examination of medical bankruptcy in 2001. See Himmelstein, 2005, *supra* note 7. In the 2007 study, the number of debtors who met the 2001 definition for medical bankruptcy—defined as a debtor with over \$1,000 in medical debt at the time of filing—increased from 46.2% to 69.1%. Himmelstein, 2009, *supra* note 1, at 744.

21. Himmelstein, 2009, *supra* note 1, at 742.

22. Himmelstein collected data on bankruptcy filings by reviewing all of the 118,308 bankruptcy petitions filed in the United States between January 25 and April 11, 2007 as well as conducting follow-up surveys and interviews with bankruptcy filers. See *id.* at 741–42. The authors defined “medical bankruptcy” debtors as those who listed medical reasons as a specific

are not the only victims of this trend. Rather, medical bankruptcy is becoming an increasingly “middle-class phenomenon.”²³ The average age of bankruptcy petitioners has increased to just over forty-four years old.²⁴ Over 60% of medical debtors attended college²⁵ and, on average, earned \$2,586 in monthly household income.²⁶ Over half of medical debtors were homeowners and three-quarters of bankruptcy petitioners or their spouses were currently employed.²⁷

The financial risk associated with medical care arises regardless of whether one has medical insurance at the onset of an illness.²⁸ Four of every five medical debtors had insurance coverage at the onset of an illness.²⁹ Certainly, going without health insurance leaves debtors responsible for significant medical expenses.³⁰ However, many

reason for their bankruptcy, who reported at least \$1000 in uncovered medical bills in the past two years, who lost at least two weeks of work-related income because of an illness or injury, or who mortgaged their home to pay for medical bills. *Id.* at 742. This broad definition is not without its critics. *See, e.g., infra* note 50 and accompanying text.

23. TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, *THE FRAGILE MIDDLE CLASS* 27 (2000) (“The people who file for bankruptcy are a cross-section of society, and bankruptcy is a middle-class phenomenon.”). Nearly one in ten debtors who filed for bankruptcy in 1997 were fifty-five or older. *Id.* at 38.

24. Himmelstein, 2009, *supra* note 1, at 743. The mean age of the 2,314 bankruptcy petitioners studied by Himmelstein was 44.4, a six-year average age increase in just ten years. *See* SULLIVAN, *supra* note 23, at 38 (noting that in 1997 the mean and median age of debtors was 38).

25. Himmelstein, 2009, *supra* note 1, at 743. Nonmedical bankruptcy petitioners attended college only slightly more frequently, at 65.8%, than did medical bankruptcy petitioners. *Id.*

26. The median monthly income of bankruptcy petitioners was \$2,225, compared to \$2,478 median income of nonmedical bankruptcy petitioners. *Id.*

27. The data reveal a 10% employment gap between medical (75.5%) and nonmedical (85%) bankruptcy petitioners. *Id.*

28. *Id.* at 744. “At illness onset, 77.9% were insured: 60.3% had private insurance as their primary coverage; 10.2% had Medicare; 5.4% had Medicaid; and 2% had Veterans Affairs/military coverage.” *Id.* Data from a separate analysis of the bankruptcy filings found that “having a basic health insurance policy does not necessarily protect these families from being crushed by the financial consequences of an illness or accident” and that “there is no clear association between identifying a medical problem [on bankruptcy petitions] and being uninsured.” Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 399–400 (2001).

29. Himmelstein, 2009, *supra* note 1, at 744.

30. Medically bankrupt families lacking health insurance at illness onset averaged \$26,971 in out-of-pocket medical expenses, compared to \$17,749 for families with coverage at the outset. *Id.* Those who lacked insurance almost universally cited its expense, and not denial of coverage because of a pre-existing condition, as the reason that they did not have insurance. Only 2.8% of those who lacked coverage reported that they were denied coverage because of a

debtors either have “skimpy” health insurance or lose coverage after getting sick, leaving them responsible for significant medical expenses.³¹ In 2007, medical debtors insured at the onset of an illness were saddled with an average of \$17,749 in out-of-pocket expenses,³² with hospital bills, prescription drugs, doctors’ bills, and premiums constituting the largest direct expenses.³³ Over 90% of medical debtors had at least \$5,000 in medical debt or had debt that was equal to 10% of their pretax income.³⁴ The indirect expenses of medical care, such as transportation, lodging for family, and childcare also contribute to the cost.³⁵ One study of breast cancer patients found that patients with comprehensive health insurance shouldered \$1,455 in monthly out-of-pocket medical expenses, with indirect costs accounting for more than half of these expenses.³⁶

Job or income loss as a result of illness compounds the costs of medical care.³⁷ Individuals may be stripped of health insurance as a result of job loss.³⁸ Out-of-pocket expenses increased, on average, by

preexisting condition, and 0.3% indicated that they thought, prior to illness, that medical coverage was unnecessary. *Id.*

31. Himmelstein, 2005, *supra* note 7, at W5-72; *see also* LESLIE J. CONWELL & JOEL W. COHEN, MEDICAL EXPENDITURE PANEL SURVEY, STATISTICAL BRIEF #73: CHARACTERISTICS OF PERSONS WITH HIGH MEDICAL EXPENDITURES IN THE U.S. CIVILIAN NONINSTITUTIONALIZED POPULATION, 2002 (2005). Among patients in the top 5% of medical expenses, more than one-third had out-of-pocket expenses that exceeded 10% of family income, and nearly one-fifth had expenses that exceeded 20% of family income. *Id.*

32. Himmelstein, 2009, *supra* note 1, at 744.

33. *Id.* Hospital bills were the single largest out-of-pocket expenses for nearly half of patients. The largest hospital bill expenses were for prescription drugs (18.6%) and doctors’ bills (15.1%). Premiums represented the largest out-of-pocket expense for only 4.1% of patients. *Id.*

34. *Id.* at 741.

35. *See* Ahsan M. Arozullah et al., *The Financial Burden of Cancer: Estimates From a Study of Insured Women with Breast Cancer*, 2 J. SUPPORTIVE ONCOLOGY 271, 274 (2004).

36. *Id.* Direct medical expenses contributed to 41% of out-of-pocket expenses, while indirect expenses, such as transportation, childcare and restaurant meals, accounted for half of these expenses. *Id.* at 274–75.

37. *See* Himmelstein, 2009, *supra* note 1, at 744. Over one-third of debtors reported that someone in the patient’s family had lost or quit a job on account of a medical event. “In 19.9% of families suffering a job loss, the job loser was a caregiver.” *Id.*

38. *Id.* Between the onset of illness and bankruptcy, private coverage fell 6.2% (60.3% to 54.1%), with a 6.6% drop in the number of employers contributing to coverage (43.2% to 36.6%). *Id.* In a study of long-term disability benefits, 27% of companies surveyed dismissed employees, stripping them of health and life insurance benefits, once they filed for long-term disability; 24% more dismissed employees at a set interval after filing, typically six to twelve

more than \$4,600 for those who lost coverage as their illness wore on as compared to those who kept insurance coverage throughout an illness.³⁹ Safety net programs for long-term illnesses may not be enough; government disability benefits are intentionally pegged low,⁴⁰ and private employers may not offer disability insurance at all.⁴¹ As a result, debts—medical or otherwise—that were manageable on a full salary can quickly become overwhelming when income drops as a result of an illness or injury.⁴²

Incurring debt is only part of the story; the cost of financing medical bills adds additional expense. Between the ubiquity of standard credit cards, patients' growing financial responsibility at the time of treatment,⁴³ and medical providers' assertiveness in

months. Joseph Pereira, *To Save on Health-Care Costs, Firms Fire Disabled Workers*, WALL ST. J., July 14, 2003, at A1.

39. Patients who had private insurance but lost it once they fell ill averaged \$22,568 in out-of-pocket expenses, compared to \$17,749 in out-of-pocket liability of those who kept insurance. See Himmelstein, 2009, *supra* note 1, at 744. In Himmelstein's earlier 2005 study, patients who initially had but lost coverage actually averaged higher out-of-pocket expenses than those who never had insurance at all. See Himmelstein, 2005, *supra* note 7, at W5-69. This phenomenon disappeared in his 2009 study. Himmelstein, 2009, *supra* note 1, at 744.

40. U.S. disability and rehabilitation programs are "designed to avoid supporting people at their prior levels of income." See SULLIVAN, *supra* note 23, at 159. The average monthly social security benefit for a disabled worker was just \$1,067 in 2010. See *Annual Statistical Report on the Social Security Disability Insurance Program, 2010*, SOC. SEC. ADMIN. 18 (Aug. 2011), available at http://www.ssa.gov/policy/docs/statcomps/di_asr/2010/sect04.pdf. And fewer than half of workers who applied for disability benefits received any assistance at all; in 2009, the award rate of social security benefits to disabled workers was just 34.5%. *Id.* at 142.

41. See Cathryn Miller-Wilson, *Becoming Poor: Stories of the Real "Safety Net" and the Consequences for Middle America*, 13 QUINNIPIAC HEALTH L.J. 1, 12 (2009). "[F]ewer than half of all employers with fewer than one hundred employees offer disability insurance." *Id.* What's more, 63% of all disabling injuries or illnesses occur outside the workplace, which disqualifies employees from receiving workers compensation and increases the need for private disability insurance. See *An Employer's Guide to Disability Income Insurance*, AM.'S HEALTH INSURANCE PLANS 4 (2007), available at http://www.assurantemployeebenefits.com/816/aebcom/xhtml_clip/disabilityedu/employersguide.pdf.

42. SULLIVAN, *supra* note 23, at 159. Families are hit with a "double whammy" of financial pressure; debts that were manageable on a full salary fall into arrears while on disability. *Id.* Penalties and credit expenses, if used to pay for expenses while on disability, plunge households further into debt. *Id.* at 160. "Whether fired for absenteeism or resigning due to illness, every day thousands of Americans find themselves without a job or unable to maintain a job, due to illness." Miller-Wilson, *supra* note 41, at 8.

43. "Nearly 80% of bankruptcy filers had received medical services or goods resulting in some self-pay obligation within two years before they filed for bankruptcy." Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y, L. & ETHICS 239, 287 (2010).

collections,⁴⁴ credit devices are commonly used to finance medical debt—a trend that is expected to grow.⁴⁵ In 2001, patients charged \$19.5 billion in medical expenses to Visa cards alone,⁴⁶ and current estimates place the total volume of credit card expenditures for medical expenses in the tens of billions.⁴⁷ Some debtors have even taken out second mortgages to pay for medical expenses.⁴⁸

For many, medical bills consume a large percentage of their household income.⁴⁹ Yet, despite the high cost of medical care, it is unclear whether medical expenses can be cited as the direct cause of many bankruptcies.⁵⁰ Individual and family budgeting is variable,

44. See COKER GROUP, MAXIMIZING BILLING AND COLLECTIONS IN THE MEDICAL PRACTICE 42–43 (2007). The report advises medical providers to adopt a policy instructing staff members to call for a billing manager when a patient states that they cannot make payment at the time of treatment. “The manager should take the patient to a private room to discuss payment. The element of authority imposed by the billing or practice manager indicates that nonpayment is unacceptable.” Above all, the report admonishes, “It’s your money—ask for it!” *Id.*; see also Anna Wilde Mathews, *Healthy Consumer: Beyond Co-Pay: Surprise Bills at the Doctor’s: To Ensure They Get Paid, Doctors Seek Entire Bill For Patient Upfront*, WALL ST. J., Aug. 5, 2009, at D1. A survey reported that more than half of medical providers collected more than merely co-pays from patients at the time of visit. *Id.*

45. See Jacoby & Holman, *supra* note 43, at 245, 253.

46. Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 559 (2006).

47. See Jacoby & Holman, *supra* note 43, at 253. Twenty-nine percent of low and middle-income households cited medical expenses as contributing to current levels of credit card debt. CINDY ZELDIN & MARK RUKAVINA, THE ACCESS PROJECT, BORROWING TO STAY HEALTHY: HOW CREDIT CARD DEBIT IS RELATED TO MEDICAL EXPENSES 1 (2007), available at http://www.accessproject.org/adobe/borrowing_to_stay_healthy.pdf.

48. See Himmelstein, 2009, *supra* note 1, at 743, 745. Of debtors surveyed, 5.7% had mortgaged their home to pay for medical bills and a total of 6.8% of debtors had recently borrowed money to pay medical bills. *Id.* In a 2001 study, researchers found that 15% of all homeowners who had taken out a second or third mortgage did so to pay medical bills. Himmelstein, 2005, *supra* note 7, at W5-68.

49. Among citizens with medical expenditures in the top 5% of the nation, one-third had out-of-pocket expenses that consumed at least 20% of family income. See CONWELL & COHEN, *supra* note 31.

50. See David Dranove & Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFF. W74 (2006). Dranove and Millenson have strongly rebuked Himmelstein’s studies for his failure to provide a causal link between nonmedical conditions and bankruptcy. *Id.* at w75. Pointedly, Dranove and Millenson argue that Himmelstein’s definition of medical bankruptcy employs circular logic. By contending that a medical debt that has already been paid off by the debtor contributes to bankruptcy by taking away savings or income that could have been used for other non-medical household expenses—expenses which ultimately lead to bankruptcy—Himmelstein and his partners, Dranove and Millenson argue, have reached the “meaningless conclusion that all expenditures are responsible for all bankruptcies.” *Id.* at w77. The critique concludes by noting that because “all debts are fungible, it is inappropriate to

debt is fungible, and the bankruptcy filings from which many researchers' conclusions are drawn are often ambiguous in terms of which event—if any—caused the bankruptcy-inducing debt.⁵¹ Yet, the fact remains that insurance premiums continue a relentless march upward,⁵² and the costs of health care continue to tug at the pocketbooks of insured middle-class consumers.⁵³

II. RISING COST OF MEDICAL CARE INCREASES CONSUMER BURDEN

Consumers have shared responsibility for the cost of their medical care since the rise of the modern health insurance industry.⁵⁴ Early employer-based health plans offered “hospital insurance,” which covered surgical and in-hospital treatment, while consumers paid doctors and physicians directly for routine care.⁵⁵ In 1929, consumers forked over 79% of all health care spending.⁵⁶ However, expansion of

single out any one form of debt as the proximate cause of bankruptcy,” and that medical debt is a much smaller part of the burden on debtors than the Himmelstein study contends. *Id.* at w77–w78. One co-author of the Himmelstein study, Melissa Jacoby, defended the study’s methodology, arguing that the use of credit cards to pay for medical services creates “invisible medical debt” on bankruptcy court records, as the debt appears as mere credit debt and not a medical expense. *See* Jacoby & Holman, *supra* note 43, at 275. Medical debt stands apart from other financial obligations, Jacoby argued, because of the diligence patients showed in paying it off. *Id.* at 287. Some filers with the largest out-of-pocket expenses within two years of bankruptcy included no medical providers as creditors, indicating that paying for medical expenses was a priority for debtors and therefore, medical debt can be singled out among other expenses as a cause of subsequent bankruptcy. *Id.* at 287–88.

51. *See* Dranove & Millenson, *supra* note 50.

52. Family premiums for employer-sponsored health plans doubled between 2003 and 2009, far outpacing the 13% growth of median family income over the same period. *See* CATHY SHOEN ET AL., *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits*, COMMONWEALTH FUND 4 (Dec. 2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Dec/1456_Schoen_state_trends_premiums_deductibles_20032009_ib_v2.pdf.

53. *See, e.g.*, SULLIVAN, *supra* note 23. In twenty-eight states in 2009, the average annual premium for family coverage consumed at least 18% of median family income. *See* SHOEN ET AL., *supra* note 52, at 5. Also in 2009, the average deductible for family plans was \$1,610 for coverage obtained through an employer with more than 50 employees and \$2,662 for coverage obtained through a smaller employer. Both were increases of at least 66% since 2003. *Id.*

54. *See, e.g.*, HARRY A. SULTZ & KRISTINA M. YOUNG, *HEALTH CARE USA* 35 (7th ed. 2011); Nancy S. Jecker, *Can an Employer-Based Health Insurance System Be Just?*, 18 J. HEALTH POL. POL'Y & L. 657, 659–60 (1993).

55. *See* SULTZ & YOUNG, *supra* note 54, at 68–69.

56. William D. White, *Market Forces, Competitive Strategies, and Health Care*

private insurance and the growing costs of care made an out-of-pocket finance system “untenable.”⁵⁷ In 1960, out-of-pocket payments accounted for 56% of health care spending; fifteen years later it was just 33%.⁵⁸ Meanwhile, health care spending skyrocketed.⁵⁹ In less than twenty-five years, the percent of national income spent on health care nearly doubled, from 7% in 1970 to 13.4% in 1993.⁶⁰

A. *The Rise and Fall of Managed Care*

In the 1980s and 1990s, insurers and employers turned to managed care plans to reduce escalating health care spending.⁶¹ The rise of managed care, most typically offered to consumers as a Health Maintenance Organization (“HMO”), is well documented.⁶² In an HMO, an insurer amasses consumers, tightly controls utilization of medical services, and extracts concessions from physicians and hospitals seeking to serve the HMO’s hordes of patients.⁶³ Consumers’ share of out-of-pocket health care costs in a managed care plan is greatly reduced, typically amounting to insignificant co-pays.⁶⁴ Yet, consumers may only visit in-network providers and are at the mercy of plan administrators who must approve certain procedures.⁶⁵ For a brief period, managed care appeared to stunt the

Regulation, 2004 U. ILL. L. REV. 137, 141.

57. *Id.* at 144.

58. *Id.* at 143–44.

59. Total health care spending as a percent of gross domestic product increased from 5.2% in 1960 to 17.6% in 2009. See CENTERS FOR MEDICARE & MEDICARD SERVICES, NATIONAL HEALTH EXPENDITURES AGGREGATE, PER CAPITA AMOUNTS, PERCENT DISTRIBUTION, AND AVERAGE ANNUAL PERCENT GROWTH, BY SOURCE OF FUND (2010), available at <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>. In per capita terms, health spending increased 5,500%, from \$147 per person in 1960 to \$8,086 in 2009. *Id.*

60. See White, *supra* note 56, at 146.

61. See *id.* at 150–52. The number of HMOs peaked in 1987 at 651, while enrollment continued to increase throughout the 1990s, nearly tripling between 1985 and 1996. See Steven J. Balla, *Markets, Governments, and HMO Development in the 1990s*, 24 J. HEALTH POL. POL’Y & L. 215, 217 (1999).

62. See, e.g., Debra A. Draper et al., *The Changing Face of Managed Care*, 21 HEALTH AFF. 11, 13 (2002).

63. *Id.*

64. See James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 JAMA 1880, 1881 (2004).

65. The focus of managed care plans was the influence of physicians, who were seen as

explosive growth of health care costs.⁶⁶ By 1995, direct consumer spending for physician services had dropped to just 12%,⁶⁷ and health care spending as a share of national income had leveled off, dropping from 13.4% in 1993 to 13.1% in 1997.⁶⁸ Managed care plans proliferated; in 1999, an estimated 186.8 million people were enrolled in some type of managed care plan.⁶⁹

But objections to managed care came from many circles.⁷⁰ Consumers (and comedians alike) scorned the maze of referrals needed to receive care.⁷¹ Physicians were similarly chafed by the interference and second-guessing of HMO administrators.⁷² Employers, too, were not seeing the promised reduction in the cost of

experts that had primary influence over health utilization decisions and with whom insurers could more easily negotiate and bargain for concessions on prices charged for medical services. *Id.*

66. Of course, managed care was not the only reason that health care spending slowed and, in some measures, decreased in the mid-1990s—if it was a cause at all. *See* White, *supra* note 56, at 153. Rather, the important factor is that managed care grew in popularity, in part, as a result of its perceived success in depressing health care costs. *Id.*

67. Consumer spending on physician services stood at 35% in 1975. *Id.* From 1990 to 1995 total out-of-pocket expenditures fell from 23% to 17.2%. *Id.*

68. *Id.*

69. *Id.* The growth of managed care was truly spectacular. HMO enrollment was limited to just nine million Americans in 1980—4% of the population. *See* Balla, *supra* note 61. By 1996, enrollment had ballooned to 63 million Americans, a six-fold increase. *Id.*

70. *See* James C. Robinson & Paul B. Ginsburg, *Consumer-Driven Health Care Promise and Performance*, 28 HEALTH AFF. w272, w273 (2009). Resentment for managed care was a “strange phenomenon” that came from numerous sources. Patients believed that the referral requirements and utilization reviews were an HMO’s attempts to limit access to care, physicians resented second-guessing of medical decisions by insurer bureaucrats, liberals saw managed care as a roadblock to single-payer health insurance, and conservatives “favored personal responsibility over government and corporate paternalism.” *Id.*

71. Pressure on managed care plans stemmed from consumers who “are becoming more active health care participants and are demanding more choice, greater flexibility, and fewer restrictions on access and service delivery.” Draper et al., *supra* note 62, at 11. Following a short hospital stay for dehydration, Tonight Show host Jay Leno was quick to criticize his “really bad HMO.” “[F]or X-rays, they had to take me over to Burbank Airport and put me through the baggage.” Mike Fleeman, *Jay Leno Jokes About Hospitalization*, PEOPLE (Apr. 27, 2009), available at <http://www.people.com/people/article/0,,20275154,00.html>.

72. Predictably, medical professionals argued that “medical policy must derive solely from the physician community.” John Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 398 (2003). Philosophic advocates of consumer-driven plans assailed HMOs for purporting to know the preferences of consumers and using formulae and other utilization controls to control the discretion of physicians. *See* Robinson & Ginsburg, *supra* note 70, at w272–73.

providing medical insurance⁷³ and were left with few alternatives: reducing or eliminating coverage for employees, reducing salaries or other benefits, or increasing employees' contributions toward their health coverage.⁷⁴ Health care policy experts and intellectuals joined the fray, arguing that managed care's tight controls unnecessarily interfered with the proper functioning of medical markets.⁷⁵

B. Consumers Get a Choice

In the wake of the "backlash" to managed care, consumer-driven health care plans gained popularity.⁷⁶ High Deductible Health Plans ("HDHPs") remove utilization and administrative controls and empower consumers to choose their preferred provider and receive the treatment that they deem necessary.⁷⁷ Premiums are lower than in managed care plans, but consumers pay higher deductibles, co-insurance and out-of-pocket expenses before triggering the support of their insurer.⁷⁸ Insurers rely on consumers to create a marketplace for

73. Between 2000 and 2009, the cost of health insurance premiums paid by employers and insureds nearly doubled, rising to nearly \$12,000 in 2007, with employees annually contributing an average of \$3,281. See Adam Larson, *The Promises and Pitfalls of Health Savings Accounts*, 18 ANNALS HEALTH L. 119, 121 (2009). One possible explanation for the rise in premiums for managed care plans was the drive of insurers to increase enrollment in managed care plans by slashing premiums to make the plans more attractive to employers and consumers. When utilization controls proved insufficient to depress costs, insurers had to readjust and increase premiums. See James C. Robinson, *From Managed Care To Consumer Health Insurance: The Fall And Rise Of Aetna*, 23 HEALTH AFF. 43, 46-47 (2004).

74. See Robinson & Ginsburg, *supra* note 70, at w272-73.

75. See *id.* at w274; see also Robinson, *supra* note 64.

76. Robinson, *supra* note 64. It should be noted, however, that the rise of consumer-driven health plans was not solely a response to the disadvantages of managed care plans. Rather, as early as the late 1980s, commentators began pushing for a health care system that made consumers more conscious of the costs of care and which employed managed competition and premium subsidies in a manner strikingly similar to reform measures that took hold in the following decades. See, e.g., Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, 320 N. ENG. J. MED. 29, 31-33 (1989).

77. See Robinson & Ginsburg, *supra* note 70, at w274.

78. See, e.g., REGINA E. HERZLINGER, MARKET-DRIVEN HEALTH CARE 281-82 (1997); see also Robinson, *supra* note 64. In a paradigmatic high-deductible consumer-driven plan, preventative care is not a covered expense. However, as employers and insurers recognize the value of preventative care, many plans provide complimentary or discounted preventative care. See A. Mark Fendrick & Michael E. Chernew, "Fiscally Responsible, Clinically Sensitive" Cost Sharing: Contain Costs While Preserving Quality, 13 AM. J. MANAGED CARE 325, 326 (2007).

providers, who proponents argue will compete for the business of consumers like typical market actors.⁷⁹ Evidence has shown that consumer sensitivity to out-of-pocket expenses and co-insurance reduces moral hazard and consumption of medical care.⁸⁰ To consumer-choice enthusiasts, medical costs increased under managed care because “[t]here is no consumer in most of the health care system . . . [and] users do not know the costs of the services they use, and the payers do not know how the users feel about them.”⁸¹

C. Choice Comes With a Price

Consumer-driven health plans aren’t without critics. Some have argued that health care and medical treatment fundamentally aren’t—or shouldn’t be—commodities open to market forces.⁸² One cannot

79. “The consumer’s right freely to choose his or her provider would be extended to the provider’s right freely to set his or her own prices.” Robinson & Ginsburg, *supra* note 70, at w274.

80. See Robinson, *supra* note 64. Insurers have “renounce[d] one-size-fits-all approaches” of managed care and taken the “focus away from the supply (physician) and toward the demand (consumer) side of the health care market[.]” *Id.* at 1880. An early RAND study found that total health care expenditures for persons in a catastrophic health plan with a large family deductible were 15% less than expenditures for persons with a 25% coinsurance rate. Gail A. Jensen, *Making Room for Medical Savings Accounts in the U.S. Health Care System*, in AMERICAN HEALTH CARE: GOVERNMENT, MARKET PROCESS, AND THE PUBLIC INTEREST 119, 127 (Roger D. Feldman ed., 2000). “A substantial body of empirical research suggests that cost-sharing at the point of purchase significantly reduces health care expenditures.” *Id.* Researchers found that the presence of higher deductibles reduced utilization, even for care that was exempt from deductibles and cost sharing. See Mary Reed et al., *High-Deductible Health Insurance Plans: Efforts to Sharpen a Blunt Instrument*, 28 HEALTH AFF. 1145, 1145 (2009). Increasing co-pay requirements by “just a few dollars” has a “marked impact” on prescription fill rates. Fendrick & Chernew, *supra* note 78, at 325.

81. See HERZLINGER, *supra* note 78, at 249–50. Under managed care plans, proponents of consumer-choice plans argue, consumers became “complacent” about their health care and did not take time to weigh the costs and benefits of particular procedures. See Bill Brubaker, *Co-Pay or You Pay? Firms Hope Worker-Directed Health Plans Will Curb Rising Costs*, WASH. POST, July 28, 2002, at H01. And beyond economic benefits, empowering consumers is intellectually consistent with the country’s disposition toward individual choice. “‘We shop around for a car, for a house, for anything else,’ [Vice President at Leesburg-based AH&T Technology Brokers, Inc., John] Love said. ‘But when it comes to health care, are we going to shop for the best price for a reconstructive surgery? Probably not.’” *Id.*

82. See DANIEL CALLAHAN, TAMING THE BELOVED BEAST 94 (2009). Citing a 1963 study by Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, Callahan argues that “health care is different from other areas of economic activity [and presents] many aspects that will make a good medical market hard to achieve.” *Id.*

place a price on a doctor's bedside manner or, in an emergency situation, shop around for the least expensive care.⁸³ And, if "good information" is the lifeblood of effective markets,⁸⁴ whether consumers have access to and can discriminate between information regarding their care is an open question.⁸⁵ While a consumer has the "ability to 'Google' a topic and download information about the disease . . . the institutions required to facilitate the availability of information needed to enable the effective functioning of markets, in large part, do not exist."⁸⁶ Furthermore, typical financial incentives like high deductibles and coinsurance have little impact on the

83. ROBERT A. LEVINE, *SHOCK THERAPY FOR THE AMERICAN HEALTH CARE SYSTEM* 7–11 (2009). According to Levine, "informed choice . . . is a mirage in health care." Many patients cannot comparison shop, particularly for emergency care, because of the transaction costs of doing so (consumers' lack of expertise or mobility or the existence of a monopoly in the specialist community). *Id.* at 10–11. Furthermore, when consumers "shop" for medical services, cost is only one of the factors that they take into account, and "no physician wants to be known as the cheap provider in a community." *Id.* at 8–9.

84. John Schneider & Robert Ohsfeldt, *The Role of Markets and Competition in Health Care Reform Initiatives to Improve Efficiency and Enhance Access to Care*, 37 CUMB. L. REV. 479, 502 (2006).

85. See Thomas L. Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217 (2009). "A central challenge" for reform proposals relying on greater consumer choice "is finding the means to effectively channel market forces given many deeply embedded features of our system and the peculiar economics of health care delivery and financing." *Id.* at 218. Yet, proponents of great choice in health care argue such channels of information will be opened when consumers are empowered to make their own decisions.

At present . . . the American public clearly lacks the information it needs to choose among providers and insurers . . . [But,] a consumer-controlled health care market would cause an explosion of such information: Surveys of health care market practitioners, like the Zagat restaurant surveys; *Consumer Reports* evaluations of procedures, insurers, and technology; and local equivalents of *Boston* magazine's annual "Best Doctors in Boston" feature would mushroom.

HERZLINGER, *supra* note 78, at 266.

86. Schneider & Ohsfeldt, *supra* note 84, at 503, 509. "Health care is different from other areas of economic activity, presenting many aspects that will make a good medical market hard to achieve." CALLAHAN, *supra* note 82, at 94. According to Callahan, the irregular and unpredictable demand for medical care, requirement of trust between the patient/consumer and doctor/seller, limited entry of consumers and providers into the field, and the patients' dearth of expertise and knowledge differentiate medical care from other consumer transactions. *Id.* In contrast, proponents of consumer-driven plans acknowledge that "health care is not a 'widget'" but argue that "there exist numerous other goods and services that are sufficiently complex that value and quality are not immediately transparent to those engaging in market transactions." See Schneider & Ohsfeldt, *supra* note 84, at 504.

affluent, and some argue that “to be truly effective with the middle class, deductibles and co-pays would have to be much higher.”⁸⁷

The growth of paradigmatic HDHPs has been “anemic,” and insurers have begun offering plans that incorporate consumer-choice principles without abandoning all administrative control.⁸⁸ Health Savings Accounts (“HSAs”), which received congressional sanction in 2003,⁸⁹ and Preferred Provider Organizations (PPOs)⁹⁰ offer “moderate decentralization” of choice whereby “a dose of lay decision-making [by consumers is] superimposed on a skeleton of managed care.”⁹¹ PPOs tend to provide less comprehensive care, averaging Actuarial Values between 80% and 84%, while an HMO typically covers 93% of expected medical costs.⁹² By 2008, 58% of consumers with employer-based health insurance enrolled in a PPO; 8% enrolled in a consumer-driven plan with a savings option like an HSA.⁹³ HMOs retained just 20% of consumers in employer-provided coverage.⁹⁴

87. LEVINE, *supra* note 83, at 12. “Of all the health care myths that are accepted as common wisdom by many U.S. politicians and citizens, the biggest impediment to effective reform appears to be the belief that market forces are the best therapy for the current crisis.” *Id.* “[T]he maldistribution of resources among social classes and the technical sophistication required for rationing choices suggest that rationing through individual purchasing decisions by consumers will not achieve equitable results, and that some management of care decisions will be necessary.” See Jacobi, *supra* note 72, at 409.

88. Robinson & Ginsburg, *supra* note 70, at w275.

89. See Richard L. Kaplan, *Who’s Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 548–49 (2005). In an HSA, employers couple a high-deductible catastrophic health plan with contributions to a savings account that employees use to pay for medical expenses. *Id.*

90. A PPO allows enrollees to access a wider network of physicians, though it offers discounts for services rendered by certain preferred providers, in exchange for a higher plan deductible. This freedom of access, while much greater than an HMO, is less than the high-deductible health plan ideal and is premised on the idea that PPO plan administrators can extract significant concessions (and thus cost-savings) from providers seeking to receive the ‘preferred’ connotation. See Robinson & Ginsburg, *supra* note 70, at w276–77.

91. See Jacobi, *supra* note 72, at 407; see also Robinson & Ginsburg, *supra* note 70, at w275. Health Savings Accounts and Preferred Provider Organizations replace “administrative controls with incentives and information” while using health plans as an “important intermediary for structuring choices and informing enrollees about provider price and quality.” *Id.*

92. See CHRIS L. PETERSON, CONGRESSIONAL RESEARCH SERVICE, SETTING AND VALUING HEALTH INSURANCE BENEFITS 2 (Apr. 6, 2009).

93. See Robinson & Ginsburg, *supra* note 70, at w275–76.

94. *Id.* at w276.

The health insurer Aetna is a prime example of the ebbing of managed care and emergence of health plans laced with consumer principles.⁹⁵ After amassing millions of managed care enrollees at unsustainable pricing, Aetna was forced to hike premiums by double digits, a pace that it unabashedly acknowledged exceeded cost trends.⁹⁶ It moved away from managing risk to “shar[ing] risk with its various stakeholders” by hiking deductibles and out-of-pocket expenses.⁹⁷ And it left the door open to further changes “if and when [employers] became willing to face the resulting backlash from beneficiaries.”⁹⁸ In just three years, Aetna cut the number of HMO enrollees by over 50%—a total of 4.45 million individuals—and its total insurance enrollment dropped by 55%.⁹⁹ Enrollment in its PPO plan, however, slid just 9% over the same span.¹⁰⁰

III. “HEALTH INSURANCE REFORM IS THE LAW OF THE LAND”¹⁰¹

On March 23, 2010, after a lengthy and tumultuous campaign for reform,¹⁰² President Barack Obama signed the Patient Protection and

95. See Robinson, *supra* note 73, at 45–48.

96. *Id.* at 47.

97. *Id.* at 48.

98. *Id.* at 48–49.

99. *Id.* at 51.

100. *Id.*

101. President Barack Obama, Remarks by the President on Health Insurance Reform, Univ. of Iowa Field House, Iowa City, Iowa (Mar. 25, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-university-iowa-field-house-iowa-city-iow>.

102. Among other complaints, Republican opponents to the reform measure characterized it as a “job-killing government takeover of health care.” Office of Rep. John Boehner, Blog: *Ten Facts Every American Should Know About Democrats’ Final Government Takeover of Health Care* (Mar. 19, 2010), <http://www.johnboehner.house.gov/blog/?postid=177141>. Citizens outside the Capitol building protesting on the eve of the bill’s passage accused Democratic leaders of being communists, socialists, and putting America on the path of “government tyranny.” Dana Milbank, *The Republicans Who Stirred the Tea*, WASH. POST, Mar. 22, 2010, at A1. When the bill passed the U.S. House of Representatives, it failed to receive a single Republican vote, the first time that a major piece of social legislation passed on a completely partisan vote. See Dan Balz, *Historic Win or Not, Democrats Could Pay a Price*, WASH. POST, Mar. 21, 2010, at A1. Opposition to the reform bill remains fervent; ten months after its passage, Republicans in the U.S. House of Representatives voted to repeal the Affordable Care Act. See David M. Herszenhorn & Robert Pear, *House Votes for Repeal of Health Law in Symbolic Act*, N.Y. TIMES, Jan. 19, 2011, at A1.

Affordable Care Act into law.¹⁰³ While trumpeting the Act as “major reform,”¹⁰⁴ the President maintained that it preserved “choice” and “competition” for private health care plans while maintaining the existing employer-based system.¹⁰⁵ Reform was necessary, the Obama administration asserted, to provide security for Americans “who right now face bankruptcy because of unpaid health bills.”¹⁰⁶ In the face of withering Republican criticism,¹⁰⁷ President Obama defended the legislation, citing the effect that medical costs had on even medically insured individuals, some of whom “have gone bankrupt because of health care.”¹⁰⁸

The Affordable Care Act attempts to reduce or limit consumers’ share of medical costs in a variety of ways. First, the Act expands coverage to an estimated 32 million uninsured individuals and

103. The bill signed by President Obama on March 23, 2010 was substantially altered by the Health Care and Education Reconciliation Act, which was signed into law on March 30, 2010. Passage of the reform measures required a “legislative two-step” as a result of Senate parliamentary rules. See Sheryl Gay Stolberg, Jeff Zeleny & Carl Hulse, *Health Vote Caps a Journey Back From the Brink*, N.Y. TIMES, Mar. 21, 2010, at A1. The U.S. Senate initially passed a reform opposed by many House of Representatives Democrats. House Democrats sought to modify the Senate bill but soon realized, after the election of Republican Scott Brown to the Massachusetts Senate seat previously held by the late Senator Ted Kennedy, a Democrat, that Senate Democrats would no longer hold the 60 votes necessary to prevent a Republican filibuster and pass the amended House bill. Thus, House Democrats passed the Senate’s bill, setting the stage for President Obama’s signing of the Patient Protection and Affordable Care Act on March 23, 2010. The House then passed the Reconciliation Act, which modified the Affordable Care Act, in a procedural move that only required a simple majority vote in the Senate. *Id.*

104. President Barack Obama, Remarks by the President on the House Vote on Health Insurance Reform (Mar. 22, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-house-vote-health-insurance-reform>.

105. *Id.*; see also Ewen MacAskill & Andrew Clark, *Healthcare Bill: Obama Sets Out on Journey to Sell His Health Reforms to US People*, THE GUARDIAN (LONDON), Mar. 23, 2010, at 16.

106. MacAskill & Clark, *supra* note 105. President Obama, at a rally a week before signing the Affordable Care Act, cited increasing out-of-pocket expenses as requiring reform. “And even if you’ve got good health insurance, what’s happening to your premiums? What’s happening to your co-payments? What’s happening to your deductible? They’re all going up So the bottom line is this: The status quo on health care is simply unsustainable.” President Barack Obama, Remarks by the President on Health Care Reform in Strongsville, Ohio (Mar. 15, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-health-care-reform-strongsville-ohio>.

107. See *supra* note 102.

108. President Barack Obama, Opening Remarks at the White House Health Summit (Feb. 25, 2010), available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/25/AR2010022502334.html>.

families by enacting an individual mandate to carry health insurance, imposing penalties on certain businesses that do not offer health insurance to its workers, and providing subsidies for individuals who cannot afford to purchase health insurance.¹⁰⁹ Second, the Act requires states to create health insurance “exchanges” where individuals can shop for private health insurance plans, which must meet certain benefit and cost-sharing requirements in order to be sold in the exchange.¹¹⁰ Third, the Act imposes new limits on private insurance plans, including prohibiting annual and lifetime benefit caps and requiring insurance companies to spend 80 to 85 cents of every premium dollar on medical expenses.¹¹¹

A. Expanding Coverage to Uninsured

The Affordable Care Act expands health insurance coverage to an estimated 32 million Americans by imposing a mandate¹¹² requiring citizens to purchase qualifying health insurance coverage by 2014 and by penalizing large businesses that do not offer health insurance benefits to its employees.¹¹³ Uninsured individuals and families with

109. *See infra* notes 112–22 and accompanying text.

110. *See infra* notes 137–41 and accompanying text.

111. *See infra* notes 130–36 and accompanying text.

112. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 1501; The White House Blog, *The Affordable Care Act Helps America’s Uninsured* (Sept. 16, 2010), available at <http://www.whitehouse.gov/blog/2010/09/16/affordable-care-act-helps-america-s-uninsured>. Exceptions to the insurance mandate will be granted for financial hardship including for individuals for whom the lowest cost plan would exceed 8% of income and those whose income was below the tax filing threshold (\$9,350 for taxpayers under 65 and \$18,700 for couples). Exceptions will also be granted for religious objections, to American Indians, those without coverage for less than three months, undocumented immigrants in the United States, and individuals in jail or prison. *See* KAISER FAMILY FOUNDATION, FOCUS ON HEALTH REFORM: SUMMARY OF NEW HEALTH REFORM LAW 1 (Apr. 15, 2011), available at <http://www.kff.org/healthreform/upload/8061.pdf> [hereinafter SUMMARY OF NEW HEALTH REFORM LAW].

113. Individuals and families who fail to obtain coverage by 2014 will be required to pay a penalty equal to the greater of \$95 per person or 1% of taxable income, with penalties increasing in 2016 to \$750 per person (with a family maximum of \$2,085) or a 2.5% fee on taxable income. *Id.* Businesses that do not offer coverage but have more than 50 employees, at least one of which is full-time and receives an Affordable Care Act premium tax credit, will be assessed a fee of \$2,000 per full-time employee, excluding the first 30 employees. *Id.* If the employer offers insurance but at least one employee still receives a premium tax credit, the employer will pay the lesser of \$3,000 for each employee receiving a credit or \$2,000 for each full-time employee. *Id.* The federal government has taken pains to describe these provisions as

income up to 400% of the Federal Poverty Level¹¹⁴ or whose employers' coverage fails to meet minimum standards¹¹⁵ will receive subsidies to reduce the cost of obtaining coverage.¹¹⁶ In concrete terms, a family of four, with a forty year-old policyholder earning \$40,000 per year, will receive a \$10,148 tax credit and will be required to pay \$1,982 (4.95% of income) for the remaining annual premium.¹¹⁷ Individuals who fail to obtain coverage by 2014 will be subject to a tax penalty.¹¹⁸ Additional subsidies will be available to reduce out-of-pocket expenses for individuals and families with income up to 400% of the Federal Poverty Level.¹¹⁹ These subsidies will raise the Actuarial Value of eligible recipients' plans, which reduces the recipients' total financial liability for medical claims.¹²⁰

not an employer "mandate" to provide insurance but rather a "shared responsibility fee" for those employers that fail to provide health insurance. *See Newsroom: Increasing Choice and Saving Money for Small Businesses*, HEALTHCARE.GOV (June 27, 2010), http://www.healthcare.gov/news/factsheets/increasing_choice_and_saving_money_for_small_businesses.html.

114. The 2011 Federal Poverty Level (FPL) was \$10,890 for individuals and \$22,350 for a family of four. *See* 76 Fed. Reg. 3637, 3638 (Jan. 20, 2011).

115. "Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income." *See* SUMMARY OF NEW HEALTH REFORM LAW, *supra* note 112, at 2. For a definition of actuarial values, see *infra* note 120.

116. Premium tax credits will be refundable (available to individuals who do not have tax liability) and advanceable (available to the consumer before they purchase coverage and not requiring the consumer to wait to be reimbursed). *See* KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES 2 (Apr. 2010), available at <http://www.kff.org/healthreform/upload/7962-02.pdf>. The credits reduce insurance premiums to a percentage of individual or family income. *Id.* at 1. The percent of income paid toward premiums will range from 3–4% of income (for purchasers with income 133–150% FPL) to 9.5% of income (for purchasers with income 300–400% FPL). *Id.*

117. *See Health Reform Subsidy Calculator*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://healthreform.kff.org/Subsidycalculator.aspx> (enter income as "2014 dollars," annual income of "40,000," age as "40," family type of "family of 4," employee coverage of "no," and regional cost factor of "medium") (last visited Nov. 6, 2011).

118. *See supra* note 113 and accompanying text.

119. *See* SUMMARY OF NEW HEALTH REFORM LAW, *supra* note 112, at 2. Subsidies will vary according to income. Individuals with income 100–150% of the FPL will have their plans' Actuarial Value increased to 94%; 150–200% FPL will rise to 87%; 200–250% will rise to 73%; and 250–400% FPL to 70%. *Id.*

120. Actuarial value (AV) is a standard metric for comparing the percentage of medical claims paid out by a health plan and the percentage of out-of-pocket expenses borne by the consumer. *See* ROLAND MCDEVITT, CALIFORNIA HEALTHCARE FOUNDATION, ACTUARIAL VALUE: A METHOD FOR COMPARING HEALTH PLAN BENEFITS 3–5 (Oct. 2008), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthPlanActuarialValue.pdf>. AVs are expressed as a share of all medical expenses; a plan with an AV of .75

As a “bridge” to the 2014 enactment of these provisions, the Affordable Care Act established a health plan for uninsured individuals who were denied private health coverage because of pre-existing conditions.¹²¹ Yet, as of November 2010, just 8,000 Americans had enrolled in the plan.¹²²

B. Minimum Benefit Packages and Health Care Exchanges

Citing the need for “balance” between more affordable, higher deductible health plans and comprehensive plans with rich benefits, President Obama called for a set of minimum benefit standards that all new health plans must meet.¹²³ Under the Affordable Care Act, all new plans must meet at least the “bronze tier” of coverage,¹²⁴ provide

would indicate that the insurer covers 75% of expenses. *Id.* at 3. The Affordable Care Act sets maximum out-of-pocket spending limits for health plans, see *infra* note 126, but does not specify the combination of deductibles, co-payments and co-insurance a plan can deploy to meet its actuarial value requirements. See QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES, *supra* note 116, at 2. Combined with the overall limit on out-of-pocket expenses, the subsidies increase the AV of a recipient’s health plan and thus act to limit his or her total out-of-pocket liability. *Id.* at 2–3.

121. See Newsroom: *State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of November 1, 2010*, HEALTHCARE.GOV (Nov. 5, 2010), http://www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html; see also JEAN HALL & JANICE MOORE, THE COMMONWEALTH FUND, PRE-EXISTING CONDITION INSURANCE PLANS CREATED BY THE AFFORDABLE CARE ACT OF 2010, at 2 (Oct. 2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Oct/1445_Hall_PCIPs_and_the_ACA_ib_FINAL.pdf.

122. See *State by State Enrollment in the Pre-Existing Condition Insurance Plan*, *supra* note 121.

123. Obama noted,

So the general idea has been here that we should set up some minimum standards within the exchange, that a plan that people are buying into, whether it's a small business or an individual, should be at least solid enough that if your kid got sick, they're actually going to be treated, that if something happened that you weren't left with a huge bunch of out-of-pocket costs. It is true that you can always get cheaper insurance if it has really high deductibles or really high copayments or doesn't cover as many things. And so there has to be a balance that's struck there.

President Barack Obama, Remarks at the White House Health Summit (Feb. 25, 2010), available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/25/AR2010022502860.html>.

124. Pub. L. No. 111-148, § 1302, 124 Stat. 119, 167–168 (2010). The four tiers—Bronze, Silver, Gold and Platinum—are distinguished primarily on the percentage of claims covered by the plans. Bronze plans must have an Actuarial Value of .6; Silver of .7; Gold of .8; and Platinum of .9.

an essential health benefits package,¹²⁵ and cap out-of-pocket expenses to the current Health Savings Account limits (\$5,950 annually for individuals and \$11,900 for families).¹²⁶ Plans existing prior to the enactment of the Affordable Care Act on March 23, 2010 will be exempt from these benefit standards but will be subject to other new regulations.¹²⁷ “Grandfather” exceptions will continue only so long as those plans do not make “significant changes” in benefit packages or costs for consumers.¹²⁸ The Congressional Budget Office estimates that by 2013 as few as 20% of employer-based plans might

125. *Id.* §§ 1301–1302. All health plans, except grandfathered plans, *infra* note 128, must cover a comprehensive set of medical services and qualify for the “Bronze” tier of health plans. While the Department of Health & Human Services is empowered to define the minimum set of benefits that all plans must provide, the Act expressly requires that all plans cover: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care. *See* Pub. L. No. 111-148 § 1302(b), 124 Stat. 119, 163–165 (2010). The Department of Health and Human Services has largely passed on the opportunity to add a list of additional services that all health plans must provide in order to be a “qualified health plan.” Rather, in proposed rules announced in July 2011, the Department of Health and Human Services gave states the authority to determine what minimum set of benefits a plan must provide in order for the plan to be offered through the state health plan exchange. *See* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866, 41921 (proposed July 15, 2011) (to be codified at 45 C.F.R. pt. 155). In effect, a state may require that all health plans provide a very specific or an expansive set of benefits in order to be offered to consumers in the exchange. Or a state may passively permit all health plans, regardless of the skimpiness of the benefit package, be offered in an exchange so long as the insurer can show some evidence that the plan meets the required actuarial value requirement for the given tier. This choice, which greatly affects whether insurers can offer truly low-benefit, high-deductible plans, will be determined state-by-state. *See infra* note 140.

126. Pub. L. No. 111-148 § 1302(c), 124 Stat. 119, 165–167 (2010). Qualifying plans must also report cost-sharing requirements and out-of-network and claims payment information in plain language.

127. *See infra* notes 129–35 and accompanying text.

128. *See* 75 Fed. Reg. 34538, 34547 (June 17, 2010). To retain grandfathered status, health plans cannot significantly reduce benefits, raise deductibles, co-insurance or co-payment charges, lower employers’ premium contribution, or tighten or add limits on the amount the insurer will pay for covered services. The “grandfather” provision was a cornerstone of President Obama’s pledge throughout the debate leading up to passage of the Affordable Care Act. The president promised Americans that if you “like your health plan, you can keep it.” *See Newsroom: Keeping the Health Plan You Have: The Affordable Care Act and “Grandfathered” Health Plans*, HEALTHCARE.GOV (June 14, 2010), <http://www.hhs.gov/news/press/2010pres/06/20100614c.html>.

remain grandfathered and thus exempt from the Act's minimum benefits requirements.¹²⁹

In September 2010, regulations went into effect prohibiting all health plans—grandfathered or not—from placing lifetime limits on coverage, rescinding coverage when enrollees make unintentional errors on application forms or become ill, denying coverage to children with pre-existing conditions, and from placing annual limits on coverage below set targets.¹³⁰ Beginning in 2011, insurers will be required to spend 80 cents of every premium dollar from individual and small group plans and 85 cents of every large group plan premium on medical care and quality improvement.¹³¹ Rebates will be provided to consumers whose plans fail to meet the required ratio.¹³² Beginning in 2011, all non-grandfathered individual and small group plans seeking to hike premiums by over 10% will have to submit the proposed increase to a board that will review the increase for reasonableness.¹³³ In 2012, state-specific levels will be set

129. See *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, HEALTHCARE.GOV (June 14, 2010), http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

130. *Id.*

131. See *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*, HEALTHCARE.GOV (Nov. 22, 2010), http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html. Medical loss ratio is a comparison of premium dollars spent on medical care and those spent on administrative costs, including profit, overhead and marketing. *Id.* The National Association of Insurance Commissioners (NAIC) was tasked with crafting definitions of qualifying medical expenses, which the Department of Health & Human Services adopted wholesale. See National Association of Insurance Commissioners, Letter to Department of Health & Human Services Secretary Kathleen Sebelius (Oct. 27, 2010), http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

132. See *Medical Loss Ratio*, *supra* note 131. The Obama administration estimates that by 2012, up to 12 million Americans could be eligible for rebates totaling \$1.4 billion. Rick Newman, *Why Health Insurers Make Lousy Villains*, U.S. NEWS, Aug. 25, 2009, <http://money.usnews.com/money/blogs/flowchart/2009/08/25/why-health-insurers-make-lousy-villains>. Critics of the reform measure, however, cite the health insurance industry's "modest" 3.4% profit margin as evidence that premium increases are not a sign of abusive industry practices. See *id.* One health policy expert predicted that insurers would, in response, "gut" cost containment programs and "avoid the administrative expenses of managing care." Amy Goldstein, *HHS Issues Rules Governing Insurers' Overhead, Spending*, WASH. POST, Nov. 23, 2010, at A03.

133. KAISER FAMILY FOUNDATION, RATE REVIEW: SPOTLIGHT ON STATE EFFORTS TO MAKE HEALTH INSURANCE MORE AFFORDABLE 6 (Dec. 2010), available at <http://www.kff.org/healthreform/upload/8122.pdf>. Increases above 10% are not presumed unreasonable, but insurers must make publicly available information justifying the increase. *Id.*

marking the threshold above which insurers must justify premium increases.¹³⁴ Additionally, “Cadillac” health plans, or those with annual premiums in excess of \$10,200 (for individuals) or \$27,500 (for families) will be subject to a 40% excise tax.¹³⁵ The tax is intended to discourage employers from siphoning otherwise taxable employee compensation into untaxed health benefits and to reduce utilization by increasing the employees’ share of health care costs.¹³⁶

In 2014, new state-based health insurance “exchanges” will be established for individuals and businesses to shop for qualifying health plans.¹³⁷ Lower-income individuals and families seeking to use tax credits to subsidize their health plan must enroll in a plan through an exchange.¹³⁸ The exchanges are intended to promote competition among private health insurers by establishing a one-stop shop for consumers to access information about health plans, thereby reducing transaction costs, improving transparency, and increasing consumer accessibility to a variety of health plans.¹³⁹ Yet, the federal government has left to the states a critical decision that may significantly bear on the success of Affordable Care Act to reduce medically related bankruptcies. In rules issued by the Department of Health and Human Services, the federal government will let states decide whether exchanges should be “active purchasers” of health care plans, in which exchanges would extract concessions from insurers (like more expansive benefit packages or reduced deductibles) before allowing the insurer’s health plan to be offered in the exchange, or whether the exchange ought to be an “open marketplace” that permissively allows all health plans that meet the

134. *Shining a Light on Health Insurance Rate Increases*, HEALTHCARE.GOV (Dec. 21, 2010), <http://www.healthcare.gov/news/factsheets/ratereview.html>.

135. KAREN DAVIS ET AL., THE COMMONWEALTH FUND, *STARTING ON THE PATH TO A HIGH PERFORMANCE HEALTH SYSTEM: ANALYSIS OF THE PAYMENT AND SYSTEM REFORM PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010*, 21 (Sept. 2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1442_Davis_Payment%20and%20System%20Reform_923v2.pdf.

136. *Id.*

137. See 76 Fed. Reg. 41866 (July 15, 2011); see also *Health Insurance Exchanges: State Planning and Establishment Grants*, HEALTHCARE.GOV (July 29, 2010), <http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html>.

138. See SUMMARY OF NEW HEALTH REFORM LAW, *supra* note 112, at 2.

139. *Health Insurance Exchanges: State Planning and Establishment Grants*, *supra* note 137.

Affordable Care Act's minimal requirements to be sold in the exchange.¹⁴⁰

As a result, while an exchange may be a vehicle for offering choice to consumers, unless a state is willing to strongly regulate the plans offered in its exchange, the exchange will not necessarily protect consumers from the dangers of skimpy, higher-deductible plans.¹⁴¹

IV. DEATH, TAXES, AND MEDICAL EXPENSES

There is a little doubt that the Affordable Care Act will reduce the overall number of medical bankruptcies. Eliminating annual and lifetime caps and coverage rescissions immediately protects those who contract the most serious and expensive illnesses.¹⁴² And enrolling individuals in a basic health plan and capping out-of-pocket expenses could save the previously uninsured over \$15,000 in uncovered medical expenses.¹⁴³ Even so, in addressing medical bankruptcy, these costs are the low hanging fruit.¹⁴⁴ What remains is

140. The Affordable Care Act requires that state exchanges certify that all health plans offered in the exchange meet minimal benefit and cost-sharing requirements laid out in the Act. *See supra* note 124. Yet, regulations promulgated by the Department of Health and Human Services do not set a methodology for a state exchange to certify whether a health plan's benefit package meets the minimum requirements to be offered on a given tier. Rather, the regulations go no further than the plain language of the Act, giving exchanges discretion to certify any plan that meets two minimal qualifications: (i) if the health insurance issuer has provided evidence that the plan complies with the minimum benefit package; and (ii) if offering the plan in the exchange is in the interest of the consumers and employers. *See* 76 Fed. Reg. 41866, 41921 (July 15, 2011). While regulators suggest factors that states ought to consider in determining whether offering a particular health plan is in the interest of consumers and employers, 76 Fed. Reg. at 41892, the choice is up to each state exchange. Presumably, a state could determine that offering the widest possible selection of health plans is in the consumers' best interest. The state could then approve all health plans, no matter how questionable the benefit package or how likely the consumer will be liable for out-of-pocket expenses, to be offered in the exchange. In this event, the exchanges—in the hands of states that politically oppose the Affordable Care Act and are reluctant to exercise regulatory authority under the Act's banner—will do little to prevent consumers from falling victim to potentially skimpy health plans.

141. *See supra* note 140.

142. *See supra* notes 129–30 and accompanying text.

143. Before the Affordable Care Act, uninsured families averaged \$26,971 in medical expenses. *See supra* note 39. Under the Affordable Care Act, out-of-pocket medical expenses for families are capped at \$11,900 (before subsidies), resulting in potential savings of \$15,000 for a previously uninsured family. *See supra* notes 125–26 and accompanying text.

144. The tragic case of a person who loses his insurance because he lost his job, falls ill,

the thornier predicament: what effect will the Affordable Care Act have on families that are fully insured but are hard hit by out-of-pocket and indirect medical expenses that drag down a sagging budget?¹⁴⁵ Because the Affordable Care Act retains the “competitive” private structure of the health care industry,¹⁴⁶ an industry that increasingly relies on consumer sensitivity to out-of-pocket expenses, the Affordable Care Act cannot and will not completely eliminate medical bankruptcy.

As extensive research illustrates, procuring health insurance alone is not the cure for medical bankruptcy.¹⁴⁷ Rather, the collision of out-of-pocket expenses and financial insecurity thrust on insured families when illness or injury strikes is most frequently the source of financial ruin.¹⁴⁸ The Affordable Care Act does successfully chip away at this particular crisis. The Act’s limits on out-of-pocket expenses reduce an insured’s financial liability¹⁴⁹ and substantially aid eligible individuals by distributing subsidies that further reduce their out-of-pocket costs.¹⁵⁰ The out-of-pocket limits, \$5,950 for individuals and \$11,900 for families, are noteworthy improvements over the nearly \$18,000 in annual expenses paid by the average medically bankrupt family.¹⁵¹ However, the out-of-pocket limits apply only to new and not grandfathered health plans.¹⁵² While it is likely only a matter of time before all plans lose grandfathered status, many insurers—particularly those like Aetna that cut managed care plan premiums in order to entice consumers¹⁵³—will be left with little

and who subsequently files for bankruptcy makes a compelling case for passage of a reform bill. *See supra* note 106. However, the uninsured (at illness onset) represent just 20% of medical bankruptcy filers. *See supra* note 23.

145. *See supra* notes 30–42.

146. *See supra* note 105 and accompanying text.

147. *See supra* notes 28–29.

148. *See supra* notes 31–42.

149. *See supra* note 126 and accompanying text.

150. *See supra* notes 119–20 and accompanying text. However, the subsidies reducing out-of-pocket liability will apply only to families earning less than 400% of the Federal Poverty Level, which would be \$43,560 for individuals and \$89,400 for families. *See supra* notes 114, 119. The financial liability for out-of-pocket expenses may remain significant for many middle class families. *See infra* note 171 and accompanying text.

151. *Compare supra* note 126 with *supra* notes 32–36.

152. *See supra* note 127 and accompanying text.

153. *See supra* note 96 and accompanying text.

choice but to hike premiums to remain profitable and, in doing so, will lose grandfathered protection. In the meantime, however, millions of consumers will be left for years without a cap on exorbitant out-of-pocket limits.¹⁵⁴

Most notably, the out-of-pocket limits do not consider the indirect expenses of an illness or injury.¹⁵⁵ While an insured's exposure to some of the most staggering medical costs, like hospital bills, are capped under the Affordable Care Act, transportation, child care and other indirect expenses are not.¹⁵⁶ These costs are not insignificant and in some cases amount to over half of total out-of-pocket expenses.¹⁵⁷ When the "double whammy" of an illness hits—rising medical costs meeting reduced income—even the Affordable Care Act's out-of-pocket cap will be insufficient to protect against a budgetary crunch all too familiar to many low- and middle-income families.¹⁵⁸

Forebodingly, all signs point toward policyholders bumping up against the out-of-pocket maximums. First, the Affordable Care Act will only serve to encourage an industry that is hurtling towards higher deductible consumer-driven health plans.¹⁵⁹ With nearly 32 million uninsured consumers newly entering the health care marketplace,¹⁶⁰ consumer-driven plans—and their reduced premiums—will be attractive to consumers seeking plans with a low sticker price.¹⁶¹ Second, the "Cadillac" tax will render obsolete the

154. *See supra* notes 128–29 and accompanying text.

155. *See supra* notes 125–26 and accompanying text.

156. *See supra* notes 125–26 and accompanying text.

157. *See supra* notes 35–36 and accompanying text.

158. *See supra* notes 37–42. Additionally, the credit costs of paying for direct and indirect expenses will also remain a significant burden on families with few savings. *See supra* notes 46–48. The reduction in out-of-pocket liability will play a significant role in reducing these costs. Borrowing a smaller amount of principal on credit logically results in less interest owed. Yet, whether running a \$15,000 balance or \$5,950 (the out-of-pocket maximum for an individual health plan), the interest owed will remain significant and increase the individual's cost of financing medical care.

159. *See supra* notes 93–94 and accompanying text.

160. *See supra* note 112 and accompanying text.

161. *See supra* note 78. The health exchanges may actually work to exacerbate this problem. While the exchanges will create a marketplace where consumers can more easily compare health plan benefits and costs, *see supra* note 139, consumers facing a mandate to purchase a plan and armed without much in the way of expertise in health plans may simply opt for the least expensive plan. The low premiums of high deductible plans will, in this simplistic

most comprehensive plans with the lowest out-of-pocket liability for a consumer.¹⁶² Third, opposition to the restrictive utilization controls of managed care¹⁶³ will increase the popularity of high-deductible consumer-driven plans to consumers newly entering the marketplace.¹⁶⁴ Citizens now *required* by law to enroll in a health plan are likely to have strong objections to an insurer tightly managing the care for which he or she is required to pay.¹⁶⁵ Finally, insurers have been placed in a governmental vice, squeezed at the front end by a public review process of premium increases and, at the back end by requirements to spend upwards of 85% of premiums on medical services.¹⁶⁶ In order to preserve a profit margin and fund marketing and other overhead expenses, insurers will have little choice, on account of these twin pressures, but to gut their health plans of the administrative controls on which managed care plans rely.¹⁶⁷ These factors suggest that the health care industry will increasingly market and rely on higher deductible health plans and continue shifting costs onto consumers, stopped only by the Affordable Care Act's out-of-pocket limits.

scenario, be more attractive to the consumer. Savvy consumers who are heavy consumers of health care may (and hopefully do) opt for more comprehensive rather than high-deductible plans. Yet, this may serve to widen the price gap between comprehensive and high deductible plans: by choosing comprehensive health plans in large numbers, heavy health care consumers would pollute the plan's risk pool and increase the cost of insuring the group. The logical result would be higher premiums, which would further exacerbate the price gap between comprehensive and high deductible plans, which would have less expensive risk pools. Testing whether this phenomenon materializes after health exchanges are launched will be an important insight into the future growth of high deductible plans.

162. See *supra* note 135 and accompanying text.

163. See *supra* notes 70–75 and accompanying text.

164. See *supra* notes 77–78 and accompanying text.

165. See *supra* note 112. With opposition to the reform bill strong nearly a year after its passage, see *supra* note 102, it is not fanciful to imagine a scenario where citizens—required by law to purchase health insurance—may cast blame on the Obama administration for the faults and difficulties of health plans (like the utilization controls of managed care plans) that they purchased through the health plan exchanges.

166. See *supra* notes 131–33 and accompanying text.

167. High deductible plans leave the transaction costs—searching for and selecting physicians, for example—to consumers, *supra* note 77, and rely on consumers and not expensive administrative controls to drive down costs. See *supra* note 132 and accompanying text.

A. Race to the Bottom?

In the aftermath of the Affordable Care Act's full implementation in 2014, with out-of-pocket expenses reaching maximum allowable levels,¹⁶⁸ insurers will likely begin a race to the bottom. Benefit packages will be cut and riddled with deductibles and co-insurance requirements to increase insurer profitability and to woo new buyers seeking low premium plans.¹⁶⁹ President Obama recognized this possibility and wisely called for minimum standards that will help to ensure that health coverage is more than merely illusory.¹⁷⁰ Even so, despite subsidies, the expense of allowable out-of-pocket costs under the Affordable Care Act and the indirect costs of medical care are sufficient to drain the budgets of low to middle income families.

A family of four, with an annual income of \$50,000, is responsible for \$3,385 in premiums and, if stricken with illness or injury, could face up to \$6,250 in total out-of-pocket liability, chewing up nearly 20% of pretax income, even *before* factoring in indirect expenses.¹⁷¹ Surveys found that, before the Affordable Care Act, 90% of debtors had medical debt in excess of just 10% of pretax income.¹⁷² Thus, even after the applying the Affordable Care Act caps on out-of-pocket expenses, many families may find themselves facing the familiar prospect of mounting medical bills and consequent bankruptcy.

The steps required to avoid this result are undesirable. Congress must avoid using its newfound authority to modify the "minimum benefits package" in an attempt to legislate away sources of consumer strain and expense.¹⁷³ Doing so would risk making the

168. *See supra* notes 159–68 and accompanying text.

169. *See supra* note 161. While health plans offered through the exchanges must display basic information relating to a health plan's coverage and out-of-pocket requirements, *see supra* note 126, the learning curve of many consumers—whether previously uninsured or insured—will be steep and knowledge of differences in coverage may be limited.

170. *See supra* note 123 and accompanying text.

171. *See supra* note 117.

172. *See supra* note 34 and accompanying text.

173. For example, Congress could require that insurers exempt certain procedures or treatment for particular diseases from those requiring cost sharing. Alternatively, Congress could, in determining the minimum essential benefits package that all health plans must satisfy

essential health benefits package, designed to be the floor under which no health plan can venture, a political football.¹⁷⁴ Few politicians could be expected to vote against the emotional overtures of patients seeking expanded coverage for more advanced, risky and expensive treatments.¹⁷⁵ Furthermore, mandates that health plans include coverage for a host of expensive treatments would require insurers to resort to the unpopular tight utilization controls of managed care. If faced with a legal obligation to cover expensive care and difficulty raising revenues to pay for the coverage,¹⁷⁶ insurers would have little choice but to depress the number of procedures with managed care style controls or to refuse to offer plans through the health exchanges.

Furthermore, government efforts to eliminate consumers' out-of-pocket liability are impracticable. Consumer-driven plans rely on out-of-pocket expenses and deductibles to drive consumer behavior.¹⁷⁷ Insulating consumers from the effect of their health care decisions, which is the practical effect of aspiring to eliminate medical bankruptcy in the current health care system, removes market-based tools from the insurance industry's belt. While subsidies that reduce (but do not eliminate) out-of-pocket liability are necessary to ensure that all families, regardless of income, have access to health care,

to be offered through an exchange, require an ever-growing list of procedures be covered by the base package.

174. Should Congress go down the path of adding specific mandatory coverage requirements, the Affordable Care Act may become the de facto government "takeover" of the health care industry that many conservatives feared. *See supra* note 102. At present under the Affordable Care Act, the federal government has control over how premium dollars are spent, *supra* note 131, reviews private insurers' efforts to raise revenue, *supra* note 132, and, for new plans, requires that a minimum set of benefits be provided. *See supra* note 125. If Congress specifies exactly what an insurer may charge a consumer for certain procedures or whether certain procedures will be covered without any out-of-pocket expense, insurers will be left with little room to make private business decisions on coverage, revenue, or payment schemes. The federal government is already taking steps in this direction: insurers must now provide preventative services for women (like contraception and well-women visits) without charging women a co-pay, co-insurance or deductible. *See Affordable Care Act Ensures Women Receive Preventative Services at No Additional Cost*, HHS.GOV (Aug. 1, 2011), <http://www.hhs.gov/news/press/2011pres/08/20110801b.html>.

175. Imagine a child afflicted with a rare form of cancer, which is very expensive to treat, lobbying Congress to require insurers to pay for 100% of treatment costs.

176. *See supra* note 133 and accompanying text.

177. *See supra* notes 77–81, 88–94 and accompanying text.

government subsidies should not be used to insulate individuals from their own poor decisions.

If death and taxes are life's great certainties,¹⁷⁸ then illness and medical expenses are foreseeable antecedents. Families must prepare for the inevitable illness or injury by saving and making good health and personal finance decisions. Of course, high-deductible consumer-driven plans could have a disproportionate effect on lower-income family finances,¹⁷⁹ which is a threat that needs to be carefully monitored. Yet, alternatives to consumer-driven plans, like managed care, require higher premiums that may exceed family budgets and become a bar to acquiring insurance in the first place. If out-of-pocket expenses were eliminated all together for low-income families, an unrealistically expensive proposition,¹⁸⁰ then the lurking dangers of moral hazard and a vitriolic political response would be overwhelming.¹⁸¹

178. See 1 BENJAMIN FRANKLIN, WILLIAM TEMPLE & WILLIAM DUANE, MEMOIRS OF BENJAMIN FRANKLIN 619 (1837).

179. The gap of information that opponents cite as a great fault of consumer-driven health plans might be most pernicious in more poorly educated and low-income households. See *supra* notes 82–86 and accompanying text. A more poorly educated individual may struggle to analyze complex health care decisions and search for competing providers, skills that consumer-driven health plans rely on to create a vibrant health care marketplace. See, e.g., Fabian Lange, *The Role of Education in Complex Health Decisions: Evidence From Cancer Screening*, 30 J. HEALTH ECON. 43, 43–44 (Jan. 2011) (establishing that the educated make better-informed decisions regarding cancer screening and that educated women were more receptive to scientific evidence and held fewer nonscientific beliefs).

180. It would cost the federal government an additional \$4,167 to eliminate out-of-pocket expenses for a family of four headed by a forty-year-old wage earner with a \$40,000 annual income. See *Health Reform Subsidy Calculator*, *supra* note 117. This cost would be on top of the \$10,148 annual tax credit the family would receive to subsidize the purchase of a health plan. Thus, while dependent on the income of each family or individual receiving tax credits, shielding lower-income families from liability for out-of-pocket expenses could increase the costs on the federal government by as much as 40%. *Id.*

181. In a health care system where the government paid all out-of-pocket expenses, consumers would have no financial reason to refrain from utilizing care, fitting the classic case of moral hazard. See *supra* note 75 and accompanying text. Furthermore, Republican critics of the Affordable Care Act, who already believed that the reform measure was a government takeover of the private health care system, see *supra* note 102, would have a stronger argument if the government paid all out-of-pocket expenses for many families. By subsidizing premiums and out-of-pocket expenses, the federal government would yield enormous purchasing power in a large segment of the private health insurance industry, which, in addition to such public programs as Medicare and Medicaid, would give the federal government significant bargaining power against private health insurers. This prospect violates the core principles of consumer-driven health plans. See *supra* note 81 and accompanying text.

B. Inevitable Bankruptcies

While the Affordable Care Act preserves policyholders' responsibility for some medical costs, it offers protection from morally reprehensible industry behavior that strips ill or injured individuals of care when they are most vulnerable.¹⁸² No longer will lack of insurance as a result of unemployment be a death sentence to family finances.¹⁸³ Abolition of annual and lifetime benefit caps ensures that individuals stricken with the most serious diseases receive care free of economic worry.¹⁸⁴ However, in the present health care system, the Affordable Care Act cannot and should not protect consumers from their own bad choices.

For society to reap the benefits of a health care system where individuals enjoy greater choice, there must be consequences for poor decisions. Family budgeting decisions, failure to take advantage of wellness and preventative care, and utilization of care from expensive providers are individual decisions for which consumers must bear financial responsibility.¹⁸⁵ Indeed, in a health care system that increasingly relies on consumer price sensitivity, individuals and families inherently run the risk of racking up significant out-of-pocket expenses.

Removing this risk altogether is currently unrealistic. Two-thirds of all consumers with employer-based insurance already utilize plans with consumer-choice principles, and completely subsidizing the direct and indirect costs of health care for lower income families would be wildly expensive.¹⁸⁶ Thus, bankruptcy will be the last stop

182. *See supra* note 142 and accompanying text.

183. *See supra* notes 38–39 and accompanying text.

184. *See supra* notes 142–43 and accompanying text.

185. And even though health care is a unique service and consumers cannot as easily discriminate between health care providers and products as they could between other commodities, *see supra* notes 82–87, consumers can engage in preventative services and save money to head off or prepare for illnesses. These steps mirror other well-known and widely practiced consumer behavior (such as regularly servicing a car or saving up for replacement parts).

186. *See supra* note 93 and accompanying text. While the wisdom or effectiveness of consumer-driven plans is debated, *supra* notes 82–87, the direction and momentum of the nation in terms of health plan enrollment is away from the restrictive controls of managed care and toward the relative freedom of higher deductible plans. Such freedom comes with a price and the risk of significant out-of-pocket expense, of course, but that risk is one that a majority

on the line for individuals and families whose health and budgeting decisions have resulted in out-of-pocket and indirect health expenses that overwhelm their budgets. In this way, medical bankruptcy is the final safety net, albeit an undesirable one, of the privately financed, consumer-driven health care system largely preserved by the Affordable Care Act.

Therefore, the goal of the Affordable Care Act or the measure of its success should not be the elimination of medical bankruptcy. Rather, the affordability of care should be the focus. Policymakers should focus on reducing the direct costs of medical care and should take steps to ensure that out-of-pocket and indirect medical expenses do not cause responsible individuals and families to be bankrupted by disease or illness.

First, greater support should be thrown behind long-term disability benefits. Even the most financially responsible family will be rocked by the “double whammy” of direct and indirect medical expenses and prolonged income disruption.¹⁸⁷ While the Affordable Care Act anticipates the direct costs of care, it does not provide adequate support for indirect expenses. Long-term disability benefits can ensure that the costs of medical care prescribed by the Affordable Care Act do not act as a penalty against a well-prepared family whose breadwinner is unable to recover her full salary. Furthermore, additional long-term disability benefits will aid those policyholders whose insurance plans are grandfathered in under the Affordable Care Act and are not subject to its out-of-pocket limitations.¹⁸⁸

Second, officials must carefully monitor and likely boost subsidies in order to match the financial means of low-income families. As presently configured, the Affordable Care Act requires a family earning \$50,000 per year to apply up to 20% of its income to direct medical expenses.¹⁸⁹ If previous trends hold, this formula will impose too great a financial burden on even those families that save and plan with precision. Medical bills in excess of just 10% of pretax income

of insured citizens are apparently willing to accept. *See supra* notes 93–94 and accompanying text.

187. *See supra* note 42 and accompanying text.

188. *See supra* notes 128–29 and accompanying text.

189. *See supra* note 171 and accompanying text.

was the greatest contributing financial factor for 35% of families that declared medical bankruptcy in 2007.¹⁹⁰ By accurately means-testing premium subsidies and the caps on out-of-pocket expenses, the Affordable Care Act will successfully obtain near universal coverage while also reaping the benefits of the nation's privatized, consumer-driven health care finance system.

Undoubtedly, it is a fine line to set subsidy levels in a way that encourages consumer responsibility and avoids moral hazard all while ensuring that lower-income families have meaningful access to care. Yet, if subsidies are permitted to harden in their current state, then the costs of care may quickly outstrip the means of even the most well prepared families. In that case, bankruptcy courts will once again become the financial ICU of low-income individuals. Legislators ought to establish annual or more frequent reviews of subsidy levels to ensure that they accurately augment the needs of low and middle-income families.

CONCLUSION

More must be done to protect consumers from out-of-pocket expenses if the Affordable Care Act is to greatly reduce the number of citizens facing medical bankruptcy. The Affordable Care Act protects many uninsured and underinsured citizens from catastrophic costs by subsidizing the purchase of health plans and prohibiting annual and lifetime benefit caps. But the Affordable Care Act does not eliminate completely the consumers' responsibility for direct out-of-pocket expenses nor does it effectively shield consumers from the indirect expenses of an illness or injury. It is precisely when these costs collide with income interruptions due to illness or injury that many families will be pushed beyond the brink and into bankruptcy. Out-of-pocket subsidies must be boosted and carefully monitored to ensure that the real cost of health care coverage is appropriately means-tested for all citizens. Additionally, improvements in long-term disability benefits will keep families from depleting savings and drowning in debt if the family breadwinner is incapacitated.

190. *See supra* note 34 and accompanying text.

While the Affordable Care Act will reduce the number of bankruptcies related to medical debt, it is both unrealistic and unwise to expect it to completely eliminate the phenomenon. The Affordable Care Act preserves the nation's private health insurance industry, which is rapidly moving away from the tight administrative controls of managed care and toward decentralized consumer-choice plans. These plans are reliant on higher deductibles and out-of-pocket expenses to drive consumer behavior. Though out-of-pocket expenses are capped under the Affordable Care Act, the maximum allowable out-of-pocket costs are sufficient to consume a family budget and drive Americans to bankruptcy. Preventing this scenario requires eliminating out-of-pocket expenses, which would, in effect, completely insulate consumers from their own choices and wipe out incentive-laden consumer-driven health plans.

The Affordable Care Act does not take this route. Rather, it preserves the private health care system and shields consumers from the catastrophic costs of medical care. Yet, those needing frequent medical care or those unable or unwilling to plan for out-of-pocket and indirect medical expenses will likely struggle, as before the Affordable Care Act, to afford the costs of their medical care. For these individuals and their families, without improvements to disability benefits and out-of-pocket subsidies under the Affordable Care Act, bankruptcy courts will sadly remain the backstop of our nation's postreform health care industry.