HEALTH LAW ARTICLES

HEALTH REFORM AND THE AFFORDABLE CARE ACT: NOT REALLY TRUSTING THE CONSUMER

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I. INTRODUCTION

In 2010, Congress enacted two massive pieces of legislation[1] significantly affecting most aspects of the American healthcare financing and delivery industry. The general philosophical and operational approach to health reform embodied in the Affordable Care Act (ACA) is one that is heavily biased in the direction of supply-side regulation. Many provisions of the ACA have the clear intent of substantially compelling (or at the very least strongly encouraging) or prohibiting (or strongly discouraging) particular forms of behavior on the part of providers, suppliers, and insurers of healthcare services and goods.[2]

The ACA drafters for the most part either willfully ignored or affirmatively rejected the idea of allowing individual healthcare consumers to play a more dominant role in the effort to improve

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). This legislation is known as the Affordable Care Act (ACA). The United States Supreme Court upheld the ACA as a legitimate exercise of Congressional Taxing and Spending power in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2608 (2012).

2. Nat'l Phys. Alliance, *The Affordable Care Act: A Quick Guide for Physicians* (available at http://npalliance.org/wp-content/uploads/NPA-ACA.Quick_.Guide_.for_.Physicians.041311.pdf).

healthcare quality, access, or affordability in the United States.[3] Such disdain for a meaningful consumer role represents a serious and unfortunate lost public-policy opportunity.[4] This Article reflects with disappointment on that lost opportunity to exploit more fully the advantages offered by a robust healthcare marketplace.

In Part II of this Article, the supply-side concentration embraced by the ACA is described in both general terms and as exemplified in ACA provisions dealing with Medicare Advantage (MA) plans, the Independent Payment Advisory Board (IPAB), and restrictions on standard underwriting practices previously utilized by private health insurers. Following that, Part III is a lamentation on the ACA's failure to acknowledge, respect, and attempt to enhance the consumer's contribution to improved healthcare quality, access, and affordability. Specific proposals to convert Medicare from its traditional entitlement structure[5] to a premium support program are used to illustrate the possibilities of a more robust consumer focus. Drawing largely on these illustrations, rationales for expanding demand-side policy interventions are more broadly presented. The Article concludes by urging that future American legislative and regulatory forays into the healthcare-reform terrain shift their nearly exclusive focus away from the supply side of the equation toward a much greater realization of and respect for the importance of consumer conduct qua demand side of the healthcare financing and delivery equation.

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3. The exception involves the ACA provisions regarding Comparative Effectiveness Research (CER). *See infra* pt. III(B) (describing the dissemination of CER to consumers as paramount to ensuring intelligent decision-making regarding complex medical issues).

4. *See* Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?* 89 Or. L. Rev. 811, 838 (2011) (reasoning that "the far-reaching regulatory provisions of the ACA might result in a regulatory regime that distorts markets through 'excessive' consumer safeguards or that undermines the ability of payers and providers to offer alternatives that appeal to different consumer groups").

5. 42 U.S.C. § 1395 (2006).

II. THE ACA AND SUPPLY-SIDE REGULATION

A. Generally

The ACA substantially expanded the already overwhelming regulatory web[6] compelling and/or strongly financially incentivizing the activities of entities and individual professionals who engage in providing, supplying, or insuring healthcare services and goods. This expansion mainly represents an enlargement of the federal government's role in intruding into the private sector.[7]

B. Specific Examples

The ACA's supply-side, command-and-control,[8] top-down, government-determined regulatory approach to healthcare may best be understood through a few specific examples. ACA regulatory interventions relating to MA plans, the IPAB, and the design and sale of private health insurance all illustrate tangible applications of the legislation's supply-side ideology.[9]

First, in the ACA, the Congressional majority and the Obama administration sought vigorously to diminish the role of MA

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6. *See generally* Robert I. Field, *Health Care Regulation in America: Complexity, Confrontation, and Compromise* (Oxford U. Press 2007) (describing the extensive levels of healthcare regulation across the nation).

7. "The [Obama] administration's signature achievements to date involve substantial expansions of the federal government's role, be it through new federal legislation addressing health insurance and financial sector reform or massive injections of federal spending." Gillian E. Metzger, *Federalism under Obama*, 53 Wm. & Mary L. Rev. 567, 568 (2011); *but see* Robert I. Field, *Government As the Crucible for Free Market Health Care: Regulation, Reimbursement, and Reform*, 159 U. Pa. L. Rev. 1669, 1676–1677 (2011) (arguing that the relationship between government regulation and private enterprise in the healthcare arena is synergistic rather than antagonistic); Kimberly J. Morgan & Andrea Louise Campbell, *Delegated Governance in the Affordable Care Act*, 36 J. Health Pol. Policy & L. 387, 387–388 (2011) (arguing that the ACA actually embodies a diminishment of the federal government's social welfare responsibility).

8. "Command and control" regulation is defined as "specific guidelines, prescribed by a government or its agency to the affected parties, on how to comply with its mandatory requirements." BusinessDictionary.com, *Definition*, *Command and Control Regulations*, http://www.businessdictionary.com/definition/command-and-control-regulations.html (accessed Dec. 31, 2012).

9. *See* Scott W. Atlas, *How to Save America's Health Care Safety Net*, http://www.forbes.com/sites/scottatlas/2012/08/20/how-to-save-americas-health-care-safey-net/ (posted Aug. 20, 2012, 9:15 p.m.) (explaining the economic implications posed by cuts to MA plans and the effect of the newly created IPAB).

plans.[10] Traditional Medicare Part A and Part B tightly delineate the amount, scope, and duration details of any beneficiary's coverage.[11] Congress created Part C of Medicare in the form of Medicare+Choice in the Balanced Budget Act (BBA) of 1997.[12] Medicare enrollees previously enjoyed the option of joining health-maintenance organizations (HMOs) in communities where HMOs existed and chose to participate in the Medicare program. Under the BBA, however, for the first time beneficiaries could enroll for their publicly financed healthcare coverage during a coordinated open enrollment process through private fee-for-service (FFS) plans, medical savings accounts coupled with high-deductible health plans, preferred-provider organizations (PPOs), or point-of-service (POS) plans, with coverage being paid for by the federal government.[13] Power-of-the-purse options facilitating Medicare beneficiaries' choice of FFS and managed care plans were further expanded by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),[14] which, *inter alia*, changed the name of Medicare Part C to Medicare Advantage.

Participation in one of the private health plans authorized by the BBA and/or the MMA, in lieu of receiving the health coverage prescribed by traditional Medicare Part A and Part B, is optional on the part of the individual beneficiary.[15] MA plans must provide, at a minimum, the benefits assured under traditional Medicare; most MA plans compete for business by offering consumers some combination of additional benefits and cash

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10. President Obama, YouTube, *Blair House Summit: Obama Explains Medicare Advantage Changes* at 2:33 to 3:47 (goodganews posted Feb. 27, 2010) (available at http://www.youtube.com/watch?v=wmLmUGFKXAk).

11. Megan Multack, *The Medicare Program: A Brief Overview*, Fact Sheet 254, at 3 (AARP Pub. Policy Inst. Mar. 2012) (available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-program-brief-overview-fs-AARP-ppi-health.pdf).

12. Pub. L. No. 105-33, 111 Stat. 251, 275–276 (1997); *see* Robert A. Berenson & Bryan E. Dowd, *Medicare Advantage Plans at a Crossroads—Yet Again*, 28 Health Affairs w29, w30–33 (published online Nov. 24, 2008) (available at http://content.healthaffairs.org/content/28/1/w29.full.pdf+html) (explaining the history of private Medicare plans).

13. *See* GoMedicare, *Medicare Advantage*, http://www.gomedicare.com/medicare-advantage/ (accessed Dec. 31, 2012) (listing the types of Medicare Advantage plans available to seniors).

14. Pub. L. No. 108-173, 117 Stat. 2066, 2081 (2003).

15. *See e.g. id.* at 2071–2072 (describing a *voluntary* prescription drug benefit program under the MMA).

rebates.[16] In 2011, more than 11.5 million eligible Medicare beneficiaries selected an MA plan rather than traditional Medicare.[17]

Advocates of the ACA projected that the greatest amount of Medicare savings achieved by the legislation would come from changes in the magnitude of government payments to MA plans.[18] The ACA cuts $145 billion over ten years in payments from the Centers for Medicare & Medicaid Services (CMS) to MA plans.[19] According to President Obama, private MA plans were receiving "unwarranted subsidies" that "pad[ded] their profits but [did not] improve the care of seniors."[20] As a result of the ACA payment cuts (the projected reductions all being used to finance expanded health insurance benefits to lower- and middle-income potential voters not yet eligible for Medicare coverage),[21] "[i]nsurers were expected to shift the burden to beneficiaries in the form of fewer services and higher out-of-pocket costs, triggering an exodus back to traditional Medicare."[22] That dynamic predictably would set off a stampede of less financially healthy MA plans out of the marketplace, thereby depriving some Medicare beneficiaries of the MA option altogether.[23] In implicit acknowledgement of that probability and the serious disruption it would entail, CMS announced it would infuse $6.7 billion into the MA plan industry by awarding quality bonuses to hundreds of MA plans rated only average.[24] The political realities motivating the Obama admin-

16. MedPac, *Medicare Advantage Program Payment System* 1 (revised Oct. 2007) (available at http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_MA.pdf).

17. Kaiser Fam. Found., *Total Medicare Advantage (MA) Enrollment, 2011*, http://www.statehealthfacts.org/comparetable.jsp?ind=327&cat=6 (accessed Dec. 31, 2012).

18. Vicki Gottlich, Patricia Nemore & Alfred J. Chiplin, Jr., *Health Care Changes: Challenges to Medicare*, 7 NAELA J. 11, 15 (2011).

19. Ctrs. for Medicare & Medicaid Servs., *Innovations for Better Health and Stronger Medicare* (available at http://www.cms.gov/apps/docs/Innovations_for_Better_Health_and_Stronger_Medicare.pdf).

20. Robert Pear, *G.A.O. Calls Test Project by Medicare Costly Waste*, N.Y. Times A9 (Apr. 23, 2012) (available at http://www.nytimes.com/2012/04/23/health/policy/gao-says-medicare-test-project-is-wasting-8-billion.html?_r=0).

21. James C. Capretta & Tom Miller, *Obamacare's Heavy Toll on Middle Class Americans*, http://economics21.org/commentary/obamacares-heavy-toll-middle-class-americans (accessed Dec. 31, 2012).

22. Ricardo Alonso-Zaldivar, *Obama Administration Eases Pain of Medicare Cuts*, Wash. Times, http://www.washingtontimes.com/news/2011/apr/19/obama-administration-eases-pain-medicare-cuts/ (Apr. 19, 2011).

23. Michelle Andrews, N.Y. Times Prescription Blog, *Fewer Medicare Advantage Plans for Seniors*, http://prescriptions.blogs.nytimes.com/2009/12/16/fewer-medicare-advantage-plans-for-seniors/ (Dec. 16, 2009, 9:25 a.m.).

24. Alonso-Zaldivar, *supra* n. 22.

istration to reluctantly support this ill-conceived[25] bonus arrangement do not negate the general philosophy of the ACA that most elderly individuals ought to be protected against the choices required by the healthcare marketplace by having the terms of their coverage dictated to them under traditional Medicare regulations. The "CMS Chief Actuary . . . project[ed] that the ACA cuts [would] cause a decline in [MA] enrollment of one[-]third by 2017."[26]

The attack on MA plans embodied in the ACA is regrettable for several reasons. First,

> [a]lthough Medicare beneficiaries may care more about broad choice of providers than of insurance plans, those promoting health plan choice believe that the next generation of beneficiaries will have become accustomed to having and making choices among insurance products and will want to maintain that ability when they age into Medicare. The reasonably positive experience with beneficiaries[ ] choosing among many Part D offerings is often cited to support this view.[27]

Moreover, the premise undergirding the ACA's attack—that MA plans are inherently inefficient and incorrigibly dedicated to shameful profiteering—is incorrect. As explained by one set of analysts:

> [G]reater government spending on Medicare Advantage than on fee-for-service Medicare does not indicate the superior efficiency of government-administered insurance. It is guaranteed by the policy of providing these private plans with rebates calculated on the basis of high benchmarks. We pay these plans more because we choose to do so. In fact, for 2010 and 2011, Medicare Advantage plan bids averaged 100% of the amount spent on fee-for-service Medicare. By

25. *See* Ltr. from James C. Cosgrove, Dir., Healthcare, to Sen. Orrin G. Hatch, Comm. On Fin., U.S. Sen., *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings* 4 (Mar. 21, 2012) (available at http://www.gao.gov/assets/590/589473.pdf) (delineating reasons why the bonus arrangement is ill conceived).

26. Robert A. Berenson, *Implementing Health Care Reform—Why Medicare Matters*, 363 N. Eng. J. Med. 101, 101 (2010).

27. Berenson & Dowd, *supra* n. 12, at w34.

this measure, the plans were as efficient as traditional Medicare.[28]

Furthermore, the ACA purposefully attempts to negate the advantages, especially regarding creativity, created by the MA program's capitated payment model as compared to traditional Medicare's fee-for-service model.

> Fee-for-service Medicare rewards providers for delivering more services, whereas Medicare Advantage's capitation system rewards plans for keeping costs down, since they keep the unspent portion of government payments. Their payments are adjusted for enrollees' health status. Plans seek to appeal to consumers in order to be chosen over their competitors and stay in business. This combination of capitation, choice, and competition sparks the development of low-cost ways of delivering attractive benefits.[29]

The creation of the Independent Payment Advisory Board (IPAB)[30] is a second example of the ACA's unambiguous dismissal of a vision of private individuals as potentially intelligent consumers regarding the management of their own healthcare coverage. The IPAB is one of many dozens of new governmental bodies established by the Patient Protection and Affordable Care Act (PPACA) to centralize federal government power over major features of American healthcare financing and delivery.[31] The ACA places its full faith in this presidentially appointed, unaccountable bureaucracy to allocate health resources better than marketplace participants, such as patients and their physicians, possibly could.[32] Specifically, the IPAB is charged with submitting

28. Jeet S. Guram & Robert E. Moffit, *The Medicare Advantage Success Story—Looking Beyond the Cost Difference*, 366 N. Eng. J. Med. 1177, 1178 (2012).

29. *Id.*

30. 124 Stat. at 489.

31. Curtis W. Copeland, *New Entities Created Pursuant to the Patient Protection and Affordable Care Act* 1 (Cong. Research Serv. July 8, 2010) (Rpt. No. 41315) (available at https://www.aamc.org/download/133856/data/crsentities.pdf.pdf). Besides creating a plethora of additional agencies, the ACA also authorizes promulgation of a "tsunami" of new regulations. James T. O'Reilly & Melissa D. Berry, *The Tsunami of Health Care Rulemaking: Strategies for Survival and Success*, 63 Admin. L. Rev. 245, 247 (2011).

32. Meredith B. Rosenthal, *Hard Choices—Alternatives for Reining in Medicare and Medicaid Spending*, 364 N. Eng. J. Med. 1887, 1889–1890 (2011); Gail R. Wilensky, *Reforming Medicare—Toward a Modified Ryan Plan*, 364 N. Eng. J. Med. 1890, 1891

recommendations on ways to limit Medicare costs to Congress for up-or-down votes, with any particular recommendation automatically going into effect unless Congress either rejects it or adopts an economically equivalent plan.[33] The IPAB's recommendations are not subject to any judicial or administrative review, and there is no opportunity for any input or review by the Medicare beneficiaries whose coverage details would be dictated by those recommendations.[34] On March 8, 2012, the U.S. House Ways and Means Committee approved by voice vote the "Medicare Decisions Accountability Act," which would repeal the IPAB,[35] and the entire House of Representatives approved the repeal by a bipartisan vote on March 22, 2012.[36]

A third example of the ACA placing its wager on governmental command-and-control activity as the surest means to transforming health policy positively can be found in the legislation's extensive new requirements pertaining to the operations of private health insurance companies,[37] piled on top of preexisting federal statutes already imposing strict mandates and restrictions on the private health insurance industry.[38] "The ACA makes fun-

(2011) (reasoning that "[t]he ACA gives the real power to the new Independent Payment Advisory Board").

33. This provision has been challenged on the grounds that it violates the Separation of Powers doctrine. Compl., *Coons v. Geithner*, 2010 WL 3299605 at ¶¶ 216–229 (D. Ariz. Aug. 12, 2010); *see* Timothy Stoltzfus Jost, *The Real Constitutional Problem with the Affordable Care Act*, 36 J. Health Pol. Policy & L. 501, 503 (2011) (discussing how the executive branch is granted quasi-legislative and judicial powers by the ACA); Timothy Stoltzfus Jost, *The Independent Medicare Advisory Board*, 11 Yale J. Health Policy L. & Ethics 21, 30 (2011) (hinting at the potential for a separation-of-powers challenge); Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 Health Matrix 75, 118–120 (2012) (describing the structure of the separation-of-powers argument).

34. Editorial, *The Other Medicare Cutters*, Wall St. J. A14 (Apr. 20, 2011) (available at http://online.wsj.com/article/SB10001424052748704613504576269582048771132.html).

35. H.R. 452, 112th Cong. § 2 (Jan. 26, 2011).

36. H.R. 5, 112th Cong. § 202 (Mar. 29, 2012).

37. Hinda Chaikind et al., *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)* 10–11 (Cong. Research Serv. May 4, 2010) (Rpt. No. R40942) (available at http://www.ncsl.org/documents/health/PrivHlthIns2.pdf).

38. The most prominent of these preexisting statutes are: the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001–1461 (2006); the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. § 1161(a) (2006); the Mental Health Parity Act (MHPA), 29 U.S.C. § 1185a (2006); the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996); and the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd (2006); *see also* Greaney, *supra* n. 4, at 815 (stating that "[r]egulation of private insurance has long been the province of the states, which typically exercise control over capitalization, solvency, mandated

damental changes to the American health insurance system."[39] Among numerous other provisions, the ACA prohibits group health plans and issuers in the individual and group markets from excluding coverage for preexisting health conditions;[40] prohibits group health plans and issuers in the individual and group markets from basing eligibility for coverage on factors related to health status.[41] Additionally, the ACA requires issuers of group and individual health insurance policies to offer coverage on a guaranteed issue and guaranteed renewal basis,[42] and to determine premiums for such coverage using adjusted community (rather than experience) rating rules.[43] Further, it mandates that Qualified Health Plans (QHPs) approved by the Federal Department of Health and Human Services participate in the newly created state Health Insurance Exchanges, as well as compels health policy issuers in the individual and small group markets to offer coverage that includes, at a minimum, a governmentally defined "essential health benefits package."[44] In other words, the ACA prohibits private health insurers from engaging in traditional insurance underwriting activities[45] under the general premise that turning the private insurance industry into a quasi-public utility is necessary to protect consumers who are presumed to be unable to bargain for favorable terms on their own behalf.[46]

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services and providers, marketing, and claims processing . . . . However, federal authority over private insurance has also been exercised on numerous occasions").

39. Lucinda E. Jesson, *Health Insurance Reforms: Once in a Lifetime Change or Same As It Ever Was?* 7 NAELA J. 125, 132 (2011).

40. 124 Stat. at 154.

41. *Id.* at 156.

42. *Id.*; 42 U.S.C. § 300gg-1 to 300gg-2 (Supp. 2010).

43. 42 U.S.C. § 300gg(a)(1)–(2).

44. *Id.* at § 18022. This "essential health benefits package" would necessarily include, at a minimum: ambulatory care; emergency services; hospitalization; prescription drugs; maternity care; mental health and substance abuse disorder services; and pediatric care. *Id.* at § 18022(b)(1).

45. One of the key intellectual architects of the ACA has boasted of "the ACA lay[ing] out a comprehensive federal law framework for revolutionizing the underwriting practices of health insurers." Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 St. Louis U. J. Health L. & Policy 27, 28 (2011).

46. *See generally* Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. Pa. L. Rev. 1873 (2011) (discussing competing conceptions of the ideal function of health insurance); Michael Lee, Jr., *Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act*, 29 Yale L. & Policy Rev. 559, 576 (2011) (indicating that "[r]estricting health status discrimination addresses the question of the very purpose of [health] insurance").

"The potential effect on health insurers cannot be understated—the PPACA institutes significant government regulation that essentially bans the type of risk selection that has been the industry standard for decades."[47]

III. MISSED DEMAND-SIDE OPPORTUNITIES

A. Generally

As illustrated by the foregoing discussion, the ACA embodies a paternalistic bias toward protecting healthcare consumers from the risks of bad (at least as seen from the perspective of the government and some intellectual and political commentators) healthcare coverage and treatment decisions, rather than empowering and equipping consumers to engage in self-determination regarding the delivery and financing of their own healthcare. As one commentator patronizingly described it, "[i]t's wonderful to talk about 'empowering' people—but you also have to protect them, especially when their abilities, health, and finances are less than optimal."[48] The unifying ACA paradigm, which assumes that government's decision-making abilities (in contrast to those of mere citizens) necessarily must be optimal, is one of central (primarily at the federal level) planning and control of the supply side of the health-services equation through close regulation of healthcare providers, insurers, and third-party financers.[49] The

47. Charles P. Litchfield, *Taxing Youth: Health Care Reform Writes a Costly Prescription that Leaves the Young and Healthy Paying the Bill*, 85 S. Cal. L. Rev. 353, 364 (2012). *See also* Don W. King, *U.S. Health Care Reform: Comprehensive Insurance or Affordable Care?* 7 J.L. Econ. & Policy 439, 458 (2011) (explaining that "[u]nderwriting restrictions increase the prevalence of health insurance among high-risk persons").

> However, most of these requirements increase average claims costs and decrease the coverage options from which others may choose. Higher costs and fewer options decrease the supply of insurance, and a smaller supply usually leads to higher prices. In addition, underwriting restrictions and mandated benefits prevent insurers from developing less expensive and more innovative forms of insurance for persons who desire them.

Id.

48. Allan Sloan, *The Hocus-Pocus behind Paul Ryan's Medicare "Reform"*, 163 Fortune 41 (May 2, 2011). In the same breath, however, the author admits Medicare's present deficiencies by pleading, "I'm not denigrating Medicare beneficiaries—heck, I'd be one myself *if my employer's health insurance didn't offer me a better deal*." *Id.* (emphasis added).

49. Numerous provisions in the ACA delegate decision-making and regulatory power to the Secretary. *See e.g.* 42 U.S.C. § 300gg-17(a)(2)(D) (providing power to the Secretary to

paradigm is predicated on the ACA's protagonists' strong policy prejudice that actual and potential patients are so hopelessly and irretrievably vulnerable,[50] dependent, and uneducable that they need to be sheltered by government against the folly they might otherwise fall victim to as autonomous healthcare consumers. From that paradigm naturally flows the "suggest[ion] that national efforts to *limit* choice in Medicare Advantage and *guide* beneficiaries to the *most valuable* options [in the government's eyes] could improve the welfare of seniors."[51]

Limiting choice in the guise of protection makes sense if one adopts, as does the ACA, the image of patients as pawns of the healthcare system.

> If societies conceive of patients as pawns, efforts are applied to building systems that ensure patients do what is right for themselves and for the [healthcare] system, because patients cannot be trusted to do so on their own accord. In this scenario, patients are considered uninformed or generally misguided, with unpredictable and unscientific behaviors. The pawn patient is merely a function of the environment and incentives he or she is given; accordingly, [others] must be benevolently paternalistic and prescriptively decide [important matters] . . . . The role of health policy and regulation for the pawn patient is to guide every behavior because patients lack judgment to do what is right.[52]

It is true that "[m]arket solutions require educated, active consumers—a characterization that may not apply [at this very moment] to enough Medicare beneficiaries."[53] Even if one accepts the proposition that many Medicare beneficiaries presently lack

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impose penalties on insurers for noncompliance with reporting requirements).

50. *See generally* Martha Albertson Fineman, *"Elderly" as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility*, 20 Elder L.J. 101 (2012) (available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2088159) (discussing the concept of vulnerability as it applies to public policy).

51. J. Michael McWilliams et al., *Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making*, 30 Health Affairs 1786, 1792 (2011) (emphasis added).

52. Sachin H. Jain & John Rother, *Are Patients Knights, Knaves, or Pawns?* 305 JAMA 2112, 2112 (2011).

53. Michael Chernew, Dana Goldman & Sarah Axeen, *How Much Savings Can We Wring from Medicare?* 365 New Eng. J. Med. e29(1), e29(2) (2011) (available at http://www.nejm.org/doi/full/10.1056/NEJMp1110593).

sufficient preparation to act successfully as active healthcare coverage consumers, that shortcoming by no means must remain a permanent impediment to market solutions.[54] The correct response is that adequate resources should be devoted to cultivating and enhancing consumer knowledge and shopping skills, and that regulatory efforts should be redirected away from their current consumer-patronizing orientation toward creating a better environment of robust information exchange.[55] To claim otherwise is to engage in a classic, specious bootstrapping argument: namely, government created the problem of dependent consumers by regulating healthcare financing and delivery in a way that makes consumers dependent, and now that very government-created dependency prevents the marketplace from working properly; therefore, the solution must be more paternalistic regulation to solve the problem that the original regulation regime created.

B. The ACA's Split Personality on Consumer Capability

Although the ACA for the most part accentuates supply-side regulation and disparages the possibility of a meaningful consumer role in securing the goals of improved access to affordable, high-quality healthcare, there is one important part of the Act in which—quite paradoxically—its drafters and proponents acknowledge, and heavily rely upon, the capacity of consumers to make sound healthcare choices.[56] This seemingly incongruous concession to autonomous consumer control may be found in the ACA's section dealing with Comparative Effectiveness Research (CER).[57]

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54. *See* Brietta Clark, *Using Law to Fight a Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, and Cost*, 20 Annals Health L. 253, 255 (2011) (discussing the challenges pertaining to health literacy generally and potential legal responses to those challenges).

55. *Cf.* Christine K. Cassel & James A. Guest, *Choosing Wisely: Helping Physicians and Patients Make Smart Decisions about Their Care*, 307 JAMA 1801, 1801–1802 (2012) (describing the Choose Wisely campaign, which is premised on the optimistic idea that consumers are sufficiently educable regarding their own healthcare).

56. *See* 42 U.S.C. § 1320e(d)(4)–(5) (Supp. 2010) (providing support for consumers to participate as representatives on expert advisory panels).

57. *See generally* Eleanor D. Kinney, *Prospects for Comparative Effectiveness Research under Federal Health Reform*, 21 Annals Health L. 79 (2012) (illustrating how a goal of CER is to create better informed consumers); Eleanor D. Kinney, *Comparative Effectiveness Research under the Patient Protection and Affordable Care Act: Can New Bottles*

By way of background, the American Recovery and Reinvestment Act of 2009 (ARRA) authorized expenditures for the "Departments of Health and Human Services, Veterans Affairs, and Defense, and other Federal departments or agencies" to plan and conduct CER.[58] Building on this historical predicate, the ACA authorized substantial financial support to establish a new Patient-Centered Outcomes Research Institute (PCORI).[59] Within the ACA legislation, "comparative clinical effectiveness research" is defined to "mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of [two] or more medical treatments, services, and items,"[60] and the function of the PCORI is to conduct and supervise this federally funded activity. More specifically,

> [t]he purpose of the Institute is to assist *patients*, clinicians, purchasers, and policy-makers *in making informed health decisions* by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis.[61]

The ACA explicitly directs that CER findings are to be communicated to consumers (and providers) "in a manner that is comprehensible and useful to [them] in making [healthcare] decisions."[62] "[D]issemination of CER findings to consumers is an essential component of CER implementation. Consumers and patients are ultimately the target audience for CER results because they are the ones who, in consultation with their care providers, make treatment choices."[63] The deep faith that ACA

Accommodate Old Wine? 37 Am. J.L. & Med. 522 (2011) (discussing CER within the ACA context).

58. 42 U.S.C. § 299b-8 (Supp. 2010).

59. Joe V. Selby, Anne C. Beal & Lori Frank, *The Patient-Centered Outcomes Research Institute (PCORI) National Priorities for Research and Initial Research Agenda*, 307 JAMA 1583, 1583 (2012).

60. 42 U.S.C. § 1320e(a)(2)(A).

61. *Id.* (emphasis added).

62. *Id.* at § 1320e(d)(8)(A)(i).

63. Paul H. Keckley & Barbara B. Frink, *Comparative Effectiveness: A Strategic Perspective on What It Is and What It May Mean for the United States*, 3 J. Health & Life Sci. L. 53, 74 (2009). Consumers also are supposed to be intimately involved in the design and implementation of the research protocols that produce the information that is ultimately

advocates have placed in CER's ability to facilitate intelligent consumer decision-making about often complex, technical, highly consequential medical matters was exemplified by the following presidential remark:

> [CER] is an attempt to say to patients, you know what, we've looked at some objective studies out [t]here, people who know about this stuff, concluding that the blue pill, which costs half as much as the red pill, is just as effective, and you might want to go ahead and get the blue one. And if a provider is pushing the red one on you, then you should at least ask some important questions.[64]

In light of this explicit faith in consumer capacity and empowerment as applied to complex,[65] consequential medical decisions, it is difficult to understand why, throughout the rest of the ACA, demand-side intervention is essentially rejected in favor of supply-side regulation intended in significant part to protect consumers from their own helplessness in the realm of healthcare coverage. It also is ironic that much of the skepticism about CER is driven by political conservatives' apprehensions about the misuse of CER findings to surreptitiously ration medical care,[66] when proponents of individual—as opposed to governmental—responsibility ought to be applauding CER's potential to enhance and facilitate autonomous decisions on the part of consumers.

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disseminated to the consumer audience. C. Daniel Mullins, Abdulla M. Abdulhalim & Danielle C. Lavallee, *Continuous Patient Engagement in Comparative Effectiveness Research*, 307 JAMA 1587, 1587 (2012).

64. David Leonhardt, *After the Great Recession*, N.Y. Times Mag. (May 3, 2009) (available at http://query.nytimes.com/gst/fullpage.html?res=980CE7D8153BF930A35756C0A96F9C8B63&pagewanted=all).

65. *See e.g.* David M. Kent & Nilay D. Shah, *Risk Models and Patient-Centered Evidence: Should Physicians Expect One Right Answer?* 307 JAMA 1585, 1585 (2012) (illustrating the complexity of clinical decision-making).

66. *See e.g.* Leonard J. Nelson, III, *Rationing Health Care in Britain and the United States*, 7 J. Health & Biomed. L. 175, 214–216 (2011) (espousing concern over healthcare rationing); Kathryn Nix, *Comparative Effectiveness Research under Obamacare: A Slippery Slope to Healthcare Rationing* (Heritage Found. Apr. 12, 2012) (available at http://www.heritage.org/research/reports/2012/04/comparative-effectiveness-research-under-obamacare-a-slippery-slope-to-health-care-rationing) (describing the potential limit on patients' choices).

C. A Contrasting Vision

In stark contrast to the generally negative vision of consumers lying at the heart of the ACA's rejection of demand-side intervention (with the apparent exception of CER discussed above), several alternative policy proposals embodying a more positive vision of individuals and their capacities have been set on the political negotiating table for consideration. "The People Aren't Dummies approach has a proven record, and it's the opposite of Brute Force's [as embodied in the ACA] record."[67]

The most significant of these alternative proposals, predicated on the idea of adults who are presumed to be capable of autonomous action, would change traditional Medicare's defined benefit structure into a defined contribution opportunity for individual control.[68] The Debt Reduction Task Force and Bipartisan Policy (Domenici/Rivlin) Center, established (and almost immediately abandoned) by the Obama administration, suggested transitioning Medicare to a premium support program under which the government would purchase healthcare coverage directly from private insurers on behalf of Medicare beneficiaries for a fixed price, while maintaining traditionally defined (by the federal government) Medicare benefits as a default option.[69] At the same time, former Congressional Budget Office Director Alice Rivlin and Congressman Paul Ryan issued a bipartisan proposal under which people who become eligible for Medicare after 2021 would receive a voucher from the government to directly purchase private health insurance themselves.[70] Both of these proposals build on the National Bipartisan Commission on the Future of

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67. Geoff Colvin, *We're Not Dummies, So Why Can't We Fix Medicare—Once and For All?* 164 Fortune 53, 53 (July 4, 2011).

68. Kaiser Fam. Found. Program on Medicare Policy, *Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals* (last modified Sept. 23, 2011) (available at http://www.kff.org/Medicare/upload/8124.pdf).

69. Debt Reduction Task Force, *Restoring America's Future* 55–56 (Bipartisan Policy Ctr. Nov. 2010) (available at http://bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf).

70. Alice Rivlin & Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, http://budget.house.gov/news/documentsingle.aspx?DocumentID=225826 (Nov. 17, 2010); *see also* H.R. Subcomm. on Health of Comm. on Ways & Means, *A Bipartisan Approach to Reforming Medicare*, 112th Cong. 2d Sess., Test. of Alice M. Rivlin (Apr. 27, 2012) (available at http://www.brookings.edu/research/testimony/2012/04/27-medicare-rivlin) (discussing the ability of seniors to participate in the healthcare market).

Medicare's ideas concerning premium support, which culminated in 1999 in the introduction of Section 1895.[71]

These proposals all served as precursors for the proposal issued on January 27, 2011, by Congressman Ryan in his capacity as Chair of the House Budget Committee.[72] Under this premium support proposal, "[w]hen younger workers become eligible for Medicare, they will be able to choose from a list of guaranteed coverage options, enjoying the same kind of choices in their plans that members of Congress enjoy today. Medicare would then provide a payment to subsidize the cost of the plan."[73] More recent tangible iterations of the Medicare premium support concept appeared in the House Budget Committee Fiscal Year 2013 Budget Proposal,[74] the bipartisan proposal released at the end of 2011 by Congressman Ryan and Oregon Senator Ron Wyden,[75] and the Seniors' Choice Act introduced jointly by Senators Richard Burr and Tom Coburn in early 2012.[76] In one public opinion

71. H.R. Subcomm. on Health of Comm. on Ways & Means, *A Bipartisan Approach to Reforming Medicare*, 112th Cong. 2d Sess., State. of the Hon. John Breaux (Apr. 27, 2012).

72. *See generally* H.R. Comm. on the Budget, Fiscal Year 2012 Budget Resolution, *The Path to Prosperity: Restoring America's Promise* (Apr. 5, 2011) (available at http://budget.house.gov/uploadedfiles/pathtoprosperityfy2012.pdf) (detailing the Ryan proposal); *see also* Paul Ryan, *Health Care Reform: The Way Forward*, 25 Notre Dame J.L. Ethics & Pub. Policy 337, 350–351 (2011) (explaining the philosophical underpinnings of the Ryan proposal).

73. H.R. Comm. on the Budget, *supra* n. 72, at 25.

74. *See* H.R. Comm. on the Budget, Fiscal Year 2013 Budget Resolution, *The Path to Prosperity: A Blueprint for American Renewal* 14 (Mar. 20, 2012) (available at http://budget.house.gov/uploadedfiles/pathtoprosperity2013.pdf) (discussing the choices that will be available to today's youth when they reach Medicare eligibility).

75. Ron Wyden & Paul Ryan, *Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future* 2 (Dec. 15, 2011) (available at http://budget.house.gov/uploadedfiles/wydenryan.pdf) (guaranteeing a choice for Medicare beneficiaries of either remaining in the existing Medicare program or participating in a new Medicare insurance exchange with premium support from the federal government).

76. Richard Burr & Tom Coburn, *The Seniors' Choice Act: A Proposal Keeping the Promise to America's Seniors by Building a Stronger, More Sustainable Medicare Program* (Feb. 2012) (available at http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=dd0753e9-e62b-4640-9659-75099f9bd1a9). This proposal includes many other changes besides just increasing premium support. *See generally* Kaiser Fam. Found., *Comparison of Medicare Premium Support Proposals* (last modified July 26, 2012) (available at http://www.kff.org/medicare/upload/8284.pdf) (providing a side-by-side comparison of the three premium support proposals). Additionally, a variation of this approach is embodied in the Choice in Healthcare Act, which Congressman Devin Nunes is expected to introduce in 2012. This legislation would create a voluntary pilot program for a new healthcare delivery system that would replace participants' Medicare and Medicaid benefits with roughly equivalent funds put on a debit-style "Medi-choice" that participants could use to purchase the health insurance of their choice on the open market and to pay

poll conducted in March of 2012, sixty-five percent of respondents indicated a preference for Medicare benefits in the form of credit for use toward buying a private health plan, versus twenty-four percent who registered opposition to that approach.[77]

D. Rationales for More Demand-Side Attention

As even some of the supply-side critics concede, demand-side approaches to the improvement of healthcare quality, access, and affordability do not represent a radical departure from the conventional policy and practice mainstream.[78] Rather, the demand-side approaches build on and fit compatibly with several existing models of publicly funded benefit programs that respect, empower, and depend upon the informed, voluntary, and competent exercise of private choice rights by individuals. Consequently, adopting a demand-side approach to health reform would equal less of a departure from the status quo than a confirmation of successful examples of what is already demonstrably working.

One large and firmly established example of publicly financed consumer direction is that of the Social Security Old Age, Survivors, and Disability Insurance (OASDI) program.[79] Although the OASDI program does not trust participants to individually invest or manage the funds they pay into the program through mandated Federal Insurance Contributions Act (FICA) payroll tax deductions, it does trust participants enough to provide them with their benefits in the form of cash-equivalent payments that the beneficiaries are free to spend as they please.[80] It is logical to ask why the same individuals—who are all, by definition, past retirement age—can be trusted to make unconstrained spending decisions about the disposition of their government issued social

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for out-of-pocket expenses such as co-payments and deductibles. Devin Nunes, *My Health-Care Alternative for the Old and Poor*, Wall St. J. A15 (June 22, 2012).

77. *Reason-Rupe Public Opinion Survey*: *March 2012 Topline Results*, at Question 43 (Reason Found. Mar. 26, 2012) (available at http://reason.com/assets/db/13327728509738.pdf); *but see* Paul Krugman, *Medicare and Mediscares*, N.Y. Times A27 (May 27, 2011) (available at http://www.nytimes.com/2011/05/27/opinion/27krugman.html) (describing the inadequacy of a voucher program).

78. Henry J. Aaron & Austin B. Frakt, *Why Now Is Not the Time for Premium Support*, 366 N. Eng. J. Med. 877, 877 (2012) (tracing the premium support idea back to 1995).

79. 42 U.S.C. §§ 401–433 (Supp. 2010).

80. *Id.* at §§ 401–402.

insurance OASDI checks but are categorically classified as incapable of managing their own healthcare coverage dollars. A similar query might be posed regarding treatment of beneficiaries of the federal Supplemental Nutrition Assistance Program (formerly called the Food Stamp program), in whom legislators apparently have sufficient confidence to pay government benefits in the form of cash-equivalent vouchers (hence the program's earlier name), which can be spent at the program beneficiary's discretion subject to only extremely broad limits.[81]

Increasingly, Medicaid waiver dollars and dedicated state appropriations are being used to finance consumer directed forms of home- and community-based long-term care.[82] Through programs such as Cash and Counseling, individuals across the United States have proven their ability (with appropriate assistance and support) to successfully administer their public benefits in the challenging but manageable context of hiring, supervising, and managing their own service providers.[83]

Moreover, the defined contribution nature of the 2012 Ryan/Wyden "Medicare Better Health Rewards Program" proposal[84] is modeled on the longstanding, popular Federal Employees Health Benefits Program (FEHBP).[85] Under that arrangement, the federal government subsidizes premium payments to private health insurers selected by individual employees based on competitive factors that are material to the particular employee.[86] There is no good reason to devote public resources to

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81. 7 U.S.C. § 2011 (2006).

82. 42 U.S.C. § 1396d(24) (2006); *see generally* Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 Ga. St. U. L. Rev. 937, 962–966 (2010) (examining Medicaid's social and legislative history with a focus on home- and community-based long-term care).

83. Patricia San Antonio et al., *Lessons from the Arkansas Cash and Counseling Program: How the Experiences of Diverse Older Consumers and Their Caregivers Address Family Policy Concerns*, 22 J. Aging & Soc. Policy 1, 3–6 (2009); *but see* Daniela Kraiem, *Consumer Direction in Medicaid Long Term Care: Autonomy, Commodification of Family Labor, and Community Resilience*, 19 Am. U. J. Gender Soc. Policy & L. 671, 717–718 (2011) (expressing, through a feminist lens, "mixed feelings about the turn toward consumer direction in long[-]term care").

84. *See* Ron Wyden, *Medicare "Better Health Rewards" Program: Saving Medicare Money, Saves You Money*, http://www.wyden.senate.gov/priorities/medicare-better-health-rewards-program (May 23, 2012).

85. Curtis S. Florence, Adam Atherly & Kenneth E. Thorpe, *Will Choice-Based Reform Work for Medicare? Evidence from the Federal Employees Health Benefits Program*, 41 Health Servs. Research J. 1741, 1742–1743 (2006).

86. *Id.* at 1743.

enable the choice-based privileges of federal employees, only to turn around and deny similar healthcare coverage selection opportunities to older individuals solely on the basis of age.[87]

Similarly, the ACA "provides 'premium support' for people below age 65. The government will offer subsidies, in the form of tax credits, to help people buy coverage marketed by private carriers on an insurance exchange."[88] "By 2014, state-based health insurance exchanges are expected to provide consumers with a variety of private health insurance plans to consider. This would include comparisons of covered services, premiums, co-pays and deductibles, as well as out-of-pocket limits on expenses."[89] There is no legitimate reason to devote public resources to enable the choice-based privileges of people under age 65, but to deny respect and empowerment to older individuals on the basis of age per se. According to the President of the American Medical Association (AMA), "[t]he AMA supports solutions that give seniors more choices in Medicare, including reforms that give them the ability to purchase insurance in the private market with financial support."[90]

Not coincidentally, there "is [a] growing interest by employers in defined[ ]contribution insurance" as a way to more precisely align healthcare costs and incentives.[91] "Here companies would give their employees a fixed-dollar payment and allow them to choose from a menu of coverage options and make the trade-offs themselves, rather than having their bosses do it for them. Workers would pay the marginal costs of higher-priced plans," similar to Congressman Ryan's proposal in the Medicare arena.[92] Americans responding to a recent survey appeared to agree with this

87. *Id.* at 1758.

88. Robert Pear, *Support Builds for a Plan to Rein in Medicare Costs*, N.Y. Times A20 (Nov. 25, 2011) (available at http://www.nytimes.com/2011/11/25/us/politics/support-builds-for-premium-support-plan-for-medicare.html).

89. Craig Boyd Garner, Judith M. Berry & David A. McCabe, *Tracing the Evolution of American Health Care through Medicare*, 1 Health Culture & Soc'y 67, 80 (2011).

90. Peter W. Carmel, Ltr. to the Ed., *Medicare Should Offer Seniors More Choices*, Wall St. J. A14 (Mar. 1, 2012).

91. Joseph Rago, *Health Care's Coming Price Revolution*, Wall St. J. A15 (Feb. 23, 2012).

92. *Id.*

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approach to health coverage.[93] Interest among employers will intensify as they realize that under the ACA, it makes good business sense for most of them to give workers vouchers to spend on their own or to drop health coverage totally, rather than to continue covering workers under employer negotiated defined benefit plans.[94]

There are various economic[95] and political[96] considerations that must be taken into account when weighing the relative merits and flaws of the ACA supply-side paradigm versus a model that is more attuned to the potential of the consumer-side, market-oriented approach to healthcare coverage for Americans.[97] There are also powerful ethical arguments that favor serious pursuit of the consumer choice and control model. These arguments come into sharp focus when we recognize that the paramount policy and practice ought to be accomplishing the goals, or fulfilling the social covenant, of the Medicare program—namely, assuring health security for elderly Americans[98]—rather than stubbornly preserving the Medicare program in all its current detail just for the sake of maintaining the status quo. As explained cogently to a Congressional committee:

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93. *Reason-Rupe Public Opinion Survey*, *supra* n. 77, at question 41 (reporting that forty-eight percent of respondents said they would prefer employers to give them money to purchase their own coverage, in contrast to forty-one percent who would not).

94. Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?* 97 Va. L. Rev. 125, 160–161 (2011).

95. *See e.g.* Charles Blahous & James C. Capretta, *Exposing the Medicare Double Count*, Wall St. J. (opinion) A13 (May 2, 2012) (discussing the economic flaws of the ACA); Douglas Holtz-Eakin & Vernon L. Smith, *ObamaCare's Flawed Economic Foundations*, Wall St. J. (opinion) A15 (Mar. 20, 2012) (further describing the economic flaws of the ACA); D. P. Kessler, *ObamaCare's Bogus Cost Savings*, Wall St. J. (opinion) A11 (Mar. 14, 2012) (discussing the economic flaws of the ACA).

96. *See e.g.* Fred Barnes, *Ryan's Medicare Revolution*, Wall St. J. (opinion) A15 (Mar. 1, 2012) (discussing the political ramifications of Congressman Ryan's premium support proposal); Anne Schwartz, *Premium Support in Medicare* 3–4 (Mar. 22, 2012) (discussing arguments for and against the premium support proposal); Gail R. Wilensky, *Directions for Bipartisan Medicare Reform*, 366 New Eng. J. Med. 1071, 1071 (2012) (discussing, with optimism, the political ramifications of Medicare reform).

97. *See generally* Amelia M. Haviland et al., *Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save $57 Billion Annually*, 31 Health Affairs 1009 (2012) (exploring benefits and challenges of consumer-directed health insurance plans).

98. *See generally* Michael Birnbaum & Elizabeth M. Patchias, *Measuring Coverage for Seniors in Medicare Part A and Estimating the Cost of Making It Universal*, 35 J. Health Pol. Policy & L. 49 (2010) (estimating the number of seniors without full federal Medicare coverage and analyzing reform costs).

> The debate over Medicare reform is about means, not ends. There is broad agreement that Medicare spending is on an unsustainable trajectory that threatens to crowd out other priorities elsewhere in the budget. There is broad agreement that Medicare's performance in delivering services to older Americans can and should be improved. There is great controversy over how to ensure that seniors continue to receive high-value [healthcare] at a price that is affordable to them and to taxpayers.[99]

Admittedly, the contrasting supply-side and demand-side approaches to Medicare program regulation both serve the principle of social justice by redistributing finite financial resources based on the need to assure universality of coverage and pooling risk to avoid the problem of adverse selection. On the demand side, the combination of a voucher provided to individuals requiring financial assistance on a time-limited "use it or lose it" basis and the availability of reasonably priced policies marketed by insurers forced by the marketplace to compete for the business of newly economically-empowered consumers would substantially reduce, if not eliminate, individuals' incentives to wait until the last minute to purchase insurance coverage.

By guaranteeing healthcare coverage to all elderly Americans, both approaches also serve the principle of beneficence, or doing good. The motivation behind a program that would give Medicare beneficiaries a subsidy, or premium support, to purchase insurance coverage from one of multiple competing health plans is to give those plans a straightforward "incentive to provide necessary services in a cost-effective manner, which can result in lower premiums or other beneficiary costs, attracting enrollees and increasing the plan's share of the market."[100]

> Under a premium-support system, each additional test or procedure would not generate additional reimbursement from the government. Most Medicare beneficiaries live on

99. H.R. Subcomm. on Health of Comm. on Ways & Means, *Premium Support Proposals for Medicare Reform*, State. of Joseph R. Antos, 112th Cong. 7 (Apr. 27, 2012) (available at http://waysandmeans.house.gov/uploadedfiles/antos_testimony_final_04-27-2012.pdf).

100. Joseph R. Antos, *The Wyden-Ryan Proposal—A Foundation for Realistic Medicare Reform*, 366 N. Eng. J. Med. 879, 880 (2012).

> fixed incomes and are not in a position to pay more. That reality will force health plans and providers to coordinate patient care and find other efficiencies rather than perpetuating the current fragmented system.[101]

The main ethical distinction between the two approaches concerns the principle of autonomy. The ACA essentially treats the aged, insofar as healthcare coverage is involved, as helpless wards of the state to be protected against all risks (even assuming arguendo that a government defined benefit program subject to national debt crises and perpetual political machinations could ever provide such protection anyway).[102]

> Publicly financed defined health benefits invite third (insurers), fourth (employers), and fifth (government) parties into the patient-doctor relationship and increase their role. They confuse patients and medical providers as to who are the real buyers and sellers (or principals and agents) in medical matters and where the lines are drawn between what is determined personally and what must be handled politically.[103]

By contrast, "[d]efined contributions (at any level) *require* more choice and therefore are less paternalistic than defined benefits."[104] The defined contribution approach envisions the main role of government as an actor that economically empowers older individuals so that everyone has reasonable access to marketplace participation.[105] "Defined contribution payments are made more directly to beneficiaries than the various mechanisms that launder, hide, and redirect the amount and nature of defined benefit

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101. *Id.* at 881.

102. *See generally* David A. Moss, *When All Else Fails: Government as the Ultimate Risk Manager* (Harvard U. Press 2002) (discussing various governmental policies, including social security, through a risk-management lens).

103. James C. Capretta & Thomas P. Miller, *Beyond Repeal and Replace: The Defined Contribution Route to Health Care Choice and Competition* 8 (Am. Enter. Inst. Dec. 7, 2010) (available at http://www.aei.org/article/the-defined-contribution-route-to-health-care-choice-and-competition/).

104. Mark V. Pauly, *The Merits of Changing to Defined Contribution Programs*, in *Policies For an Aging Society: The Merits of Changing to Defined Contribution Programs* 217, 219–220 (Stuart H. Altman & David I. Shactman eds., Johns Hopkins U. Press 2002) (emphasis in original).

105. Michael R. Wilson, Student Author, *The Policymaker's Handbook to Entitlement Reform: A New Approach to Saving Our Seniors*, 18 Elder L.J. 159, 180 (2010).

promises through other third-party intermediaries. They would empower and encourage consumers and patients to make better [healthcare] choices."[106] Thus, the defined contribution approach both promotes individual self-determination and improves the social status of elderly persons by using public policy to send an unambiguously positive message about trust in the capacity of most elders to make decisions responsibly about the most important matters in their respective lives.

For non-elderly poor persons who have been suffering difficulties in accessing appropriate health services and achieving equal health outcomes,[107] at least in part because they lack health insurance, a voucher approach to achieving healthcare coverage also promotes respect for their decisional autonomy. Moreover, this approach additionally serves the ethical principle of equality of opportunity.[108]

As noted by Professor David Orentlicher, a liberal former Indiana state legislator:

> Under Medicaid and ACA [which creates many new second-class Medicaid patients] (but not Medicare), the interests of the poor are divorced from the interests of the well-to-do. When Medicaid and ACA expanded healthcare access, they did so primarily for the poor or lower-income families. The financially secure generally receive healthcare coverage from their employers, or can afford to purchase it on their own. Thus, those who are better off see Medicaid and ACA as programs that serve the poor at the expense of themselves. But with governmental programs like this in the United States,

106. Capretta & Miller, *supra* n. 103, at 8–9.

107. *See e.g.* U.S. Gov't Accountability Off., *Poverty in America: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions As Well As the Economic Growth Rate* 2 (Jan. 2007) (GAO Rpt. No. 07-344) (available at http://www.gao.gov/new.items/d07344.pdf) (discussing health outcomes for individuals with low incomes and their limited access to health insurance and healthcare); Nancy E. Adler & David H. Rehkopf, *U.S. Disparities in Health: Descriptions, Causes, and Mechanisms*, 29 Annual Rev. Pub. Health 235, 246 (2008) (examining health disparities associated with race, ethnicity, and socioeconomic status).

108. *See* John Rawls, *A Theory of Justice* 54 (Rev. Ed. Harvard U. Press 1999) (positing equality of opportunity as a fundamental ethical principle).

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> there generally is not sufficient political support to ensure adequate funding over time.[109]

Thus, Medicaid is, at best, a second-class health insurance program, and creating millions of new recipients of this second-class benefit is likely to have only little-to-limited impact on healthcare access and health outcomes for those millions of people.[110]

By contrast, a public policy that "cashed out" the current Medicaid system—a system that effectively segregates and stigmatizes its participants in direct contradiction to the original intent of the program[111]—and used saved public funds to subsidize a voucher or premium support program empowering beneficiaries to purchase in the marketplace the same private insurance coverage as anyone else would promote the principle of equality. If low-income individuals were enabled to purchase the same health insurance policy, from the same source, as people with greater financial means, there would no longer remain any incentive for healthcare providers to avoid treating them.[112] The replacement of Medicaid as we now know it with a voucher program that permitted everyone to participate equally with dignity in the same health insurance marketplace would provide those who need a government subsidy with an entry into the healthcare system that seamlessly integrates them into that system rather than branding them as inferior and subjecting them to discrimination on the basis of that inferiority.

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109. David Orentlicher, *Rights to Healthcare in the U.S.: Inherently Unstable*, 38 Am. J.L. & Med. 326, 337 (2012) (footnotes omitted).

110. *See* Arlene Akiwumi-Assani, *Four Problems Facing Meaningful State Health Care Reform and Coverage in the United States*, 72 Alb. L. Rev. 1077, 1078 (2009) (reasoning that "[a]lthough Medicaid, a health benefit for low[-]income individuals, covers several million Americans who would otherwise be uninsured, several inherent issues arise through astronomical spending, and covered patients may face second-class treatment by essential providers refusing to treat Medicaid patients"); Rosemary B. Guiltinan, *Enforcing a Critical Entitlement: Preemption Claims As an Alternative Way to Protect Medicaid Recipients' Access to Healthcare*, 51 B.C. L. Rev. 1583, 1593 (2010) (concluding that "low reimbursement rates can negatively impact the ability of Medicaid beneficiaries to access healthcare—particularly primary, specialty, and dental care—outside of an emergency room").

111. Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 Emory L.J. 791, 794 (2009).

112. *See e.g.* Michael Lee, Jr., Student Author, *Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act*, 29 Yale L. & Policy Rev. 559, 594–596 (2011) (discussing provider exodus from government health insurance programs).

IV. CONCLUSION

Tumult in the ways that American society pursues the business of healthcare delivery and financing presents an opportunity—indeed, an imperative—to rethink our fundamental national goals and the most advantageous avenues to achieving them. Change is both necessary and possible. "The key question is not whether health markets actually satisfy the conditions of perfect competition. Few markets actually do, up close. The relevant question is, can policy changes actually improve health market performance over the current status quo?"[113]

This query should be answered in the affirmative, but only if regulatory policy is built on respect for the demand side of the healthcare financing and delivery equation (that is, respect for the consumer), and government intervention is limited to actions dedicated to enabling and empowering autonomous consumers to:

> (1) understand that choice of health plan impacts the quality of [healthcare] they receive; (2) identify the information to look at in order to establish the quality of a health plan; (3) comprehend the information after identifying it; and (4) compare several health plans on the same variables in order to (5) arrive at a decision that reflects ones' foreseeable and unforeseeable health needs.[114]

Unfortunately, the ACA, built primarily on disdain for the educability of consumers and the paternalistic philosophy that wisdom derives from central planning and intensive regulation of the supply side, threatens to make future market failure in the healthcare arena even more of a self-fulfilling prophecy.

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113. Len M. Nichols, *Making Health Markets Work Better through Targeted Doses of Competition, Regulation, and Collaboration*, 5 St. Louis U. J. Health L. & Policy 7, 13–14 (2011).

114. Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice under the Affordable Care Act*, 74 Alb. L. Rev. 241, 255 (2010–2011).