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Advance Directive

**THE STUDENT HEALTH POLICY AND LAW REVIEW OF
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW**

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

Beazley Institute for Health Law and Policy

VOLUME 24, STUDENT ISSUE 1

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ANNALS OF HEALTH LAW
Advance Directive

Editors' Note

The *Annals of Health Law* is proud to present the Thirteenth Issue of our online, student-written publication, *Advance Directive*. *Advance Directive* aims to support and encourage student scholarship in the area of health law and policy. In this vein, this Issue explores the legal and policy issues in the health insurance industry by examining past, current, and future trends. The authors examine a variety of issues related to health insurance, ranging from the implications of Medicaid expansion under the Patient Protection and Affordable Care Act to the issues presented by narrow networks.

The Issue begins with a look at the regulation of health insurance in Illinois. First, we examine the Illinois Compassionate Use Act and how medical marijuana may affect Medicare and Medicaid reimbursement for hospital services. Our authors also explore the potential of incorporating value-based insurance design into the Illinois state exchange and Medicaid expansion. Next, our authors discuss the need for community-based, long-term care services rather than institutional-based services in the wake of Medicaid expansion in Illinois.

Our Issue continues with an analysis of Medicaid expansion across the United States under the Affordable Care Act. First, we consider Section 1115 waivers utilized in states such as Arkansas, and the benefits of such waivers. Our authors also examine how the Affordable Care Act affects vulnerable populations, deterrents to Medicaid enrollment of such populations, and the roles of state and federal government in expanding health coverage.

The Issue proceeds with an analysis of broad changes to health insurance laws and regulations throughout the United States. First, our authors examine restrictions that the Affordable Care Act places on small businesses providing health insurance coverage to employees and women seeking coverage for abortion services, and propose changes to alleviate these restrictions. Our authors further discuss the constitutionality of the Affordable Care Act's risk corridor program. We also explore narrow networks in the health insurance industry and the need for enhanced guidelines to ensure that consumers are able to choose the appropriate plan for their needs. Lastly, our authors examine antitrust liability in the health insurance industry and advocate for the repeal of the McCarran Ferguson Act, which exempts the business of insurance from most federal regulation.

Finally, our Issue concludes with a comparative look at other countries' policies concerning the pharmaceutical industry and suggests ways that the United States could change its laws to achieve a more cost-effective system. Our authors look to countries such as France, Canada, Germany, and the United Kingdom for an exploration of best practices in the pharmaceutical regulation industry.

We would like to thank Adrienne Saltz, our Technical Editor, because without her knowledge and commitment, this Issue would not have been possible. We would like to give special thanks to our *Annals* Editor-in-Chief, Anne Compton-Brown, for her leadership and support. The

Annals Executive Board Members, Leighanne Root, Jean Liu, and Matthew Brothers provided invaluable editorial assistance with this Issue. The *Annals* members deserve special recognition for their thoughtful and topical articles, and for editing the work of their peers. Lastly, we must thank the Beazley Institute for Health Law and Policy and our faculty advisors, Professor Lawrence Singer, Professor John Blum, Kristin Finn, and Megan Bess for their guidance and support.

We hope you enjoy our Thirteenth Issue of *Advance Directive*.

Sincerely,

Jessica Wolf
Advance Directive Editor
Annals of Health Law
Loyola University Chicago School of Law

Ashley Huntington
Advance Directive Editor
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Medicare, Medicaid, and Medical Marijuana: Why
Hospitals Should Not be High on Patient
Certification

*Ryan Marcus**

I. INTRODUCTION

When Illinois passed the Compassionate Use of Medical Cannabis Pilot Program Act (the Act), it sparked a burning debate as to how medical marijuana would affect hospitals.¹ Unfortunately, few resources exist to guide hospitals about the legal implications of introducing cannabis clinically. As medical marijuana businesses prepare to open in the spring of 2015, qualified patients have already begun to submit their applications for registration cards.² With patients now actively seeking physician certification of their debilitating conditions, hospitals must prepare for the imminent questions raised by a Schedule I controlled substance's legalization at the state level. This note will provide an overview as to how medical marijuana may affect Illinois hospitals in the context of reimbursement primarily through the Medicare and Medicaid programs. With careful planning and substantial discussion with medical staff, there is no reason for the Act to cause "Reef-

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1. See generally Compassionate Use of Medical Cannabis Pilot Program Act, 410 ILL. COMP. STAT. 130/ (creating the Illinois' Medical Cannabis Pilot program and allowing physicians to recommend the therapeutic use of medical marijuana to patients).

2. *Medical Marijuana ID Card Applications Top 2,000*, ASSOCIATED PRESS (Sept. 5, 2014), available at <http://chicago.cbslocal.com/2014/09/05/medical-marijuana-id-card-applications-top-2000/> (a qualified patient, as defined in the statute, is an individual who has been diagnosed by a physician as having a debilitating medical condition. Debilitating medical conditions have thus far been defined to include cancer, glaucoma, HIV, Hepatitis C, seizure disorders, and numerous other conditions as listed in § 130/10).

er Madness”³ in the management of clinical medicine.

The next part of this note begins by providing background information on the introduction of cannabis as a medical substance. Part III discusses the implementation of the Illinois Compassionate Use Act and accompanying regulations. Part IV addresses the potential effects of state legalization of medical marijuana, patient certification, and the effects on Medicare and Medicaid reimbursement. Part V examines potential federal political changes acting as a harbinger to a uniform policy on medical cannabis.

II. WHAT IS MEDICINAL MARIJUANA?

The medical application of cannabis may be broken into two primary components. The first is tetrahydrocannabinol, or THC.⁴ THC is the psychoactive component of cannabis, and has been shown to help increase appetite and reduce nausea.⁵ THC has been used in particular with cancer patients and patients suffering from the human immunodeficiency virus (HIV).⁶ Synthetic THC has been utilized in the drug Marinol for several years, an FDA-approved treatment that is covered under some insurance plans.⁷ THC has also been shown to be somewhat efficacious in reducing anxiety and as a means of improving sleep quality.⁸

3. “Reefer Madness,” originally released as “Tell Your Children” was a 1936 propaganda film revolving around the story of teenagers who become addicted to marijuana and involved in several illegal activities. REEFER MADNESS (George A. Hirliman Productions 1936).

4. NAT’L CANCER INST., *Cannabis and Cannaboids: Laboratory/Animal/Preclinical Studies*, <http://www.cancer.gov/cancertopics/pdq/cam/cannabis/healthprofessional/page4> (last modified Nov. 6, 2014).

5. Leland Kim, *UCSF Study Finds Medical Marijuana Could Help Patients Reduce Pain with Opiates*, UNIV. OF CAL. S.F. (Dec. 6, 2011), <http://www.ucsf.edu/news/2011/12/11077/ucsf-study-finds-medical-marijuana-could-help-patients-reduce-pain-opiates>.

6. NAT’L CANCER INST., *supra* note 4.

7. U.S. DEP’T OF JUSTICE, *RX Cannabis*, http://www.justice.gov/dea/divisions/sea/in_focus/marinol-cessmet.pdf (last visited Oct. 6, 2014) (explaining the pharmacology, dosage, and trials supporting the safety and effectiveness of Marinol. Marinol is used to stimulate appetite for AIDS patients suffering from anorexia resulting from the effects of the virus, as well as an antiemetic for chemotherapy-induced emesis).

8. Mark A. Ware et al., *Smoked Cannabis for Chronic Neuropathic Pain: A Randomized Controlled Trial*, 182 CANADIAN MED ASS’N J. 694, 700 (2010), available at

Cannabidiol (CBD), the second primary component of cannabis, is currently the most salient component of the medical application of cannabis. CBD is used as an oil extract from cannabis, and can be obtained to minimize or eliminate psychoactive effects.⁹ CBD oil has been shown to be particularly effective in reducing seizures.¹⁰ Studies going as far back as 1977 have shown CBD as an effective anticonvulsant with an ability to bind to receptors that inhibit electrical activity comparably to drugs clinically effective in treating and preventing major convulsions.¹¹ More recent studies have shown that CBD alone is not sufficient to negate the necessity of anti-seizure medications, but it has proven to supplement their efficacy substantially.¹² The majority of evidence supporting the efficacy of the substance does remain anecdotal, but new studies across the country may substantiate the various claims regarding the substance.¹³

In terms of clinical concerns, it is important to note that cannabis cannot be administered to a lethal overdose because cannabinoid receptors are not

<http://www.cmaj.ca/content/182/14/E694.abstract> (study involving adults with post-traumatic or postsurgical neuropathic pain and efficacy of varying strengths of cannabis in reducing various symptoms).

9. Jack Giddingson, *Cannabidiol: The Side of Marijuana You Don't Know*, CHICAGO NOW (Nov. 20, 2013, 7:11 PM) <http://www.chicagonow.com/chicago-medical-marijuana/2013/11/cannabidiol-the-side-of-marijuana-you-dont-know/>.

10. See Nicholas A. Jones et al., *Cannabidiol Displays Antiepileptiform and Antiseizure Properties In Vitro and In Vivo*, 332 J. OF PHARMACOLOGY & EXPERIMENTAL THERAPEUTICS 569, 576 (2010) (demonstrating efficacy in general seizure disorders).

11. Paul Consroe & Andrea Wolkin, *Cannabidiol—Antiepileptic Drug Comparisons and Interactions in Experimentally Induced Seizures in Rats*, 201 J. PHARMACOLOGY & EXPERIMENTAL THERAPEUTICS 26, 26 (1977).

12. Kim, *supra* note 5.

13. See Sue Hughes, *FDA Approves Cannabis Extract Study in Pediatric Epilepsy*, MEDSCAPE (Dec. 12, 2013), available at <http://www.medscape.com/viewarticle/817701> (indicating that the FDA approved studies to begin on a form of medicinal marijuana for the treatment of epilepsy in children); see also Press Release, Earth Science Tech Announces Positive Preliminary Test Results on the Effects of Its Hemp Oil Enriched With CBD-Cannabidiol on Animal Breast Cancer Cells and on Normal Cells (Oct. 9, 2014), available at <http://www.financialnewsmedia.com/profiles/etst.html> (indicating that a sponsored research agreement between Earth Science Tech, Inc. and the University of Central Oklahoma showed that the effects of Hemp Oil enriched with CBD can inhibit the proliferation of cancer cells more than that of normal cells).

located in brainstem areas affecting breathing.¹⁴ Medical concerns associated with the chronic use of cannabis include tachycardia, hypotension, conjunctival injection, bronchodilation, and decreased gastrointestinal motility.¹⁵ Additionally, cannabis may be addictive, but its addictive potential is substantially lower than other substances of abuse.¹⁶ Smoking cannabis comes with the same general cancer-related concerns and other pulmonary health risks incurred through the smoking of any other substance.¹⁷ Overall, medical cannabis may potentially be viewed as a less dangerous substitute for opiates.¹⁸

III. THE ILLINOIS COMPASSIONATE USE ACT

While there are a number of concerns relating to implications for hospitals confronting medical marijuana, the Act ultimately may render these concerns much ado about nothing. To begin, the Act reiterates the provisions of the Smoke Free Illinois Act.¹⁹ Essentially, medical marijuana may not be smoked in or near a hospital.²⁰ This aspect of the law was confirmed

14. NAT'L CANCER INST., *Cannabis and Cannaboids: Adverse Effects*, <http://www.cancer.gov/cancertopics/pdq/cam/cannabis/healthprofessional/page6> (last updated May 13, 2014).

15. *Id.*

16. *Id.*; see also Phillip M. Boffey, *What Science Says About Marijuana*, N.Y. TIMES (July 30, 2014), <http://www.nytimes.com/2014/07/31/opinion/what-science-says-about-marijuana.html> (discussing a 1999 study conducted by the Institute of Medicine on dependency rates of various substances. For a point of comparison, forty-six percent of the population was found to have ever used marijuana, with nine percent becoming dependent on it. Comparatively, seventy-six percent of the population had used tobacco, with thirty-two percent becoming dependent. Anti-anxiety medications had been used by thirteen percent of the population, with a nine percent rate of dependency).

17. NAT'L CANCER INST., *supra* note 14.

18. Philippe Lucas, *Cannabis as an Adjunct to or Substitute for Opiates in the Treatment of Chronic Pain*, 44 J. PSYCHOACTIVE DRUGS, 125, 131 (2012) ("Therefore cannabis has the potential to both relieve suffering for those suffering from chronic pain, and to reduce morbidity and mortality often associated the use and abuse of pharmaceutical opiates"); see Marcus A. Bachhuber, *Penn Study Shows 25 Percent Fewer Opioid-Related Deaths in States Allowing Medical Marijuana*, PENN MED. (Aug. 26, 2014), available at http://www.uphs.upenn.edu/news/News_Releases/2014/08/bachhuber/.

19. 410 ILL. COMP. STAT. 130/30 (2014); see Smoke Free Illinois Act 410 ILL. COMP. STAT. 82/1 (2008).

20. 410 ILL. COMP. STAT. 130/30 (2014).

in a memo issued by the Illinois Hospital Association (IHA).²¹ The IHA also noted that the law is silent on consumables, and that it will ultimately be up to hospitals as to how they wish to handle the substance in this form.²²

The Act additionally places strict requirements on which providers may certify patients for medical marijuana registry cards.²³ Only a doctor of medicine (MD) or a doctor of osteopathic medicine (DO), licensed under the Illinois Medical Practice Act of 1987, with a controlled substance license, may complete a written certification.²⁴ A certification may only be made in person, as the Act specifically forbids making a physical examination for purposes of certification through telemedicine.²⁵ A certifying physician must also possess an established bona-fide physician-patient relationship with the qualified patient.²⁶ A physician is further required to maintain a record-keeping system for all patients the physician certifies, which must be accessible by the Illinois Department of Public Health and Department of Financial and Professional Regulation.²⁷ These records are protected and privileged, and do not place the physician or hospital under additional risk of liability.²⁸ As a result, hospitals should not be concerned about patients receiving certification without a full review of their medical record by a physician treating their condition.²⁹

21. *IHA Summary: New Legislation on Medical use of Marijuana*, ILL. HOSP. ASS'N., (Aug. 5, 2013), <http://www.ihatoday.org/uploadDocs/1/pa980122summary.pdf>.

22. *Id.* at 5. (the Act describes consumables as cannabis infused products).

23. See ILL. ADMIN. CODE TIT. 77, § 946.300 (2014).

24. 410 ILL. COMP. STAT. 130/5.

25. *Id.* at 130/35.

26. *Id.* at 130/55; see Robert McCoppin, *Patients Face 'Hoop-Jumping' to Gain Medical Marijuana*, CHI. TRIB. (Aug. 16, 2014), <http://www.chicagotribune.com/lifestyles/health/ct-medical-marijuana-patient-applications-met-20140816-story.html> (“Patients and doctors do not need a prior relationship, as long as the doctor reviews the patient’s records.”); see also *Medical Marijuana ID Card Applications Top 2,000*, *supra* note 2 (providing the definition for a qualified patient).

27. 410 ILL. COMP. STAT. 130/35.

28. *Id.*

29. See Paul Merrion, *Illinois Takes Aim at State’s First Medical Marijuana Clinic*, CRAIN’S CHICAGO BUS. (Dec. 16, 2013), <http://www.chicagobusiness.com/article/20131216/NEWS02/131219823/illinois-takes-aim-at-states-first-medical-marijuana-clinic> (Illinois in-

The Illinois Legislature recently amended the Act to create a provision for children with seizure disorders.³⁰ While the provision does not go into effect until January 2015, the amendment allows the issuance of registry identification cards to qualifying patients under the age of eighteen who suffer from epilepsy or other seizure disorders.³¹ The law specifically provides the Department of Public Health with the authority to expand the qualifying debilitating conditions for individuals under eighteen to become qualified patients, but only with consent from a parent or legal guardian.³² Minors receiving certification will be restricted to the use of consumables.³³

IV. HOW MEDICAL MARIJUANA AFFECTS HOSPITALS & INSURANCE REIMBURSEMENT ELIGIBILITY

The structure of the Act effectively designates physicians as the “gatekeepers” to access to medical marijuana.³⁴ As a result, hospital staff physicians may be placed in a position where a patient suffers from a designated debilitating medical condition and wishes to be certified. A physician certification may take place in a range of settings, but it is most likely to occur on a primary care basis, or for general treatment of the particular condition.³⁵ If a Medicare or Medicaid patient seeking certification schedules an

investigated a clinic that opened in August of 2013 and charged a physician for certifying patients for medical cannabis without conducting physical examinations or establishing a legitimate physician-patient relationship. The Illinois Department of Financial and Professional Regulation issued a warning to doctors to be cautious about setting up medical cannabis clinics shortly after the investigation. This is indicative that hospitals will not see an increase of inpatient admissions who received certification at random); *Cf.* Steve Lopez, *A Visit to The Medical Marijuana Doctor*, L.A. TIMES, (Oct. 28, 2009), <http://articles.latimes.com/2009/oct/28/local/me-lopez28> (California has what are referred to as Marijuana “shops”; clinics which operate solely certify patients for medical marijuana registration cards).

30. 410 ILL. COMP. Stat. 130/60(b) (2013), *amended by* IL Pub. A. No. 098-0775 (2014).

31. *Id.*

32. *Id.*

33. *Id.*

34. *See id.* at 130/1 (certification must be completed by a physician, hence designating them as the gatekeeper to accessing a registration card and medical marijuana).

35. *See* McCoppin, *supra* note 26 (stating those seeking certification need to make appointments with physicians, and if that patient is new to the physician, then that physician

appointment to discuss certification, the physician may be placed in a difficult legal situation. Given that any billing for services under Medicare or Medicaid includes a provision of certifying compliance with all federal and state law, certifying a patient for medical marijuana may be a violation of federal law.³⁶ Thus, billing for any service related to patient certification may be considered a violation of federal law.³⁷ Billing for certification through a hospital could jeopardize both the individual physician and the hospital's ability to participate in Medicare and Medicaid.³⁸ Furthermore, the hospital would be submitting a bill for a service that may be considered illegal, which involves a process to obtain a substance the government claims has no medical value.³⁹ Seeking reimbursement for such a service may trigger False Claims Act liability.⁴⁰ However, based on physician-

must be treating the patient's disease).

36. Condition of Participation: Compliance with Federal, State and Local Laws and Regulations, 42 C.F.R. § 485.608 (2011).

37. *Id.*; see ILL. HEALTH FACILITIES & SERVS. REVIEW BD., STATE HOSP. DATA SUMMARY, 2013, <http://www.hfsrb.illinois.gov/pdf/2013%20Hospital%20State%20Summary.pdf> (for inpatient services in Illinois hospitals in 2013, Medicare and Medicaid accounted for 56.5% of payer mix. The impact of losing Medicare and Medicaid eligibility would be a death penalty); Lindsey Dunn & Scott Becker, *50 Things to Know About the Hospital Industry*, BECKER'S HOSP. REVIEW (July 23, 2013), <http://www.beckershospitalreview.com/hospital-management-administration/50-things-to-know-about-the-hospital-industry> (stating that on average, Medicare constitutes an average of 40.9% of the payer mix of a hospital, and Medicaid constitutes an average of 17.2% of payer mix).

38. Condition of Participation: Compliance with Federal, State and Local Laws and Regulations, *supra* note 36.

39. See generally DRUG ENFORCEMENT AGENCY, THE DEA POSITION ON MARIJUANA 1 (Apr. 2013), available at http://www.justice.gov/dea/docs/marijuana_position_2011.pdf (the DEA states marijuana "has a high potential for abuse, has no accepted medicinal value in treatment in the United States, and evidence that there is a general lack of accepted safety for its use even under medical supervision." Billing the government for a service that includes certifying patients for medical marijuana would be in contradiction with the DEA position. Assisting qualified patients in obtaining a Schedule I substance through certification may be equated to providing a service or consultation for the purpose of obtaining a drug with no federally recognized medical value. However, the DEA specifically stated it will prosecute only those who manufacture, distribute, or possess any illegal drugs. While this may not benefit billing concerns, it may alleviate some criminal liability for certification.)

40. See generally False Claims Act, 31 U.S.C. §3729 (a hospital may be found liable under the False Claims Act for knowingly submitting a false claim to the government for payment. The penalty for doing so is a civil fine between \$5,000 and \$10,000, plus triple the amount the government paid for the claim or claims.) A False Claims Act claim may proceed under two theories, the most likely being false certification. A false certification claim is based on certifying the compliance with certain laws as a prerequisite for billing. See U.S. *ex*

patient confidentiality, a general visit that involves certification may not be construed as a visit solely for certification, and may still be billable without falsely certifying compliance with all federal laws.⁴¹

Should a hospital choose not to bill for the certification process, the act of certification may not create liability.⁴² While the courts have not substantially addressed the legal implications of certification and billing insurance, federal courts in California have found processes similar to certification as protected under the First Amendment.⁴³ The Act specifically states the physician is ultimately certifying that a patient has a qualifying condition to be eligible for a registry card, which is likely protected under the First Amendment.⁴⁴ However, obtaining certification is the only means for a pa-

rel. Absher v. Momence Meadows Nursing Ctr., Inc., 764 F.3d 699, 711 (7th Cir. 2014). A hospital certifying compliance with all federal laws and then billing Medicare for a service that includes certifying a patient for the use of a Schedule I substance may trigger liability under this theory. *See id.* The alternate worthless services theory may also be alleged. The Seventh Circuit has not yet recognized the worthless services theory under the False Claims Act. *See id.* at 710. However, in other circuits the worthless services theory proceeded with the claim that if a provider or facility billed the government for a service that is so deficient that it is essentially the equivalent of no performance at all, the provision and billing of that service violates the False Claims Act. *Mikes v. Strauss*, 274 F.3d 687, 703 (2d. Cir. 2001). Thus, a hospital could be sued under the False Claims Act for billing Medicare or Medicaid for the certification consultation provided by a staff physician, or potentially for providing a service the government deems to be without any value.

41. *See* 410 ILL. COMP. STAT. 130/130(k).

42. *See generally id.* at 130/10; *see generally* ILL. DEP'T OF PUB. HEALTH, PHYSICIAN WRITTEN CERTIFICATION FORM, available at <http://www2.illinois.gov/gov/mcpp/Documents/Physician%20Certification%20Form%20080814.pdf>. Note, the statute and regulations refer to the process as “certification,” not prescription. The certification process itself, as demonstrated by the certification form, only certifies that the patient has one of a listed number of medical conditions, has a bona-fide patient relationship, and that the physician conducted an in person physical examination, reviewed the patient’s medical history, and explained the risks and benefits of the medical use of cannabis. The final statement the physician must certify is that in the physician’s professional opinion, the qualifying patient is likely to receive a therapeutic or palliative benefit from using medical cannabis for treatment of the debilitating medical condition or symptoms of that debilitating medical condition.

43. *See Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (California case setting the precedent on First Amendment protection of discussions of the benefits and potential concerns of medical marijuana); *see also Denney v. Drug Enforcement Admin.*, 508 F. Supp.2d 815, 832 (E.D. Cal. 2007).

44. 410 ILL. COMP. STAT. 130/5 (describing the certification process as one in which the doctor states the patient has a qualifying condition to obtain a registry card, and verifies the bona-fide physician-patient relationship. The Act also uses the phrase “cannabis and prescription medications” in section 15, indicating the intention of the state to maintain the two concepts separate from each other).

tient to obtain medical marijuana, which bears a striking resemblance to a prescription.⁴⁵ A clear answer on this issue is unlikely to arise until medical cannabis is available and litigation begins.

The interaction between the Drug Enforcement Agency (DEA) certification and insurance is perhaps the greatest liability faced by hospitals with physicians certifying patients.⁴⁶ Physicians under the Act must have a valid DEA license to certify patients.⁴⁷ However, the requirements to receive a DEA license include that all drugs listed in Schedule I may not be prescribed, administered, or dispensed for medical use.⁴⁸ Thus, if certification is construed as the equivalent to prescribing medical marijuana, the DEA may have grounds to revoke the controlled substance license of any practitioner certifying patients under the Act.⁴⁹ Consequently, physicians certifying patients at a hospital could jeopardize the DEA license of both the physicians and hospitals. Without a valid DEA license, neither a hospital as an individual entity nor its physicians may participate in Medicare or Medicaid.⁵⁰

Even if a hospital determines that it will not permit staff physicians to certify patients for medical marijuana, or allow for certification on hospital or hospital-owned premises, hospitals are faced with patients bringing their

45. See generally *id.* at 130/55.

46. See DRUG ENFORCEMENT AGENCY, OFFICE OF DIVERSION CONTROL, PRACTITIONER'S MANUAL §2 (2006), available at <http://www.deadiversion.usdoj.gov/pubs/manuals/pract/section2.htm>; see also Kay Lazar & Shelley Murphy, *DEA Targets Doctors Linked to Medical Marijuana*, BOSTON GLOBE (June 6, 2014), <http://www.bostonglobe.com/metro/2014/06/05/drug-enforcement-administration-targets-doctors-associated-with-medical-marijuana-dispensaries-physicians-say/PHsP0zRlaxXwnDazsohIOL/story.html> (describing physicians given an ultimatum in Massachusetts regarding their relationships with dispensaries. While the DEA has not replicated any similar type of action regarding physicians known to be certifying patients, the DEA is retaining its power to revoke DEA licenses for those involved with the distribution of medical marijuana).

47. 410 ILL. COMP. STAT. § 130/10.

48. DRUG ENFORCEMENT AGENCY, *supra* note 46.

49. *Id.*

50. Matthew Potter, *New Medicare Part D Rule Affects PA Prescribers*, AM. ACAD. OF PHYSICIAN ASSISTANTS (June 3, 2014), <http://www.aapa.org/twocolumn.aspx?id=2684>.

own medical cannabis into inpatient settings.⁵¹ Qualifying patients are not restricted from bringing cannabis into medical facilities, which may complicate inpatient admissions.⁵² Through triage, a nurse may indicate on the medical record that the patient is consuming cannabis without generating any legal liability.⁵³ However, if the patient is admitted into inpatient care, practitioners should avoid administering the drug directly because such administration is a clear violation of federal law and will likely complicate billing.⁵⁴ Practically, however, patients consuming medical marijuana in the hospital cannot have their use simply omitted from the record.⁵⁵ Hospitals must be wary of patients bringing the substance into the hospital and monitor other drug administration closely. Complications from ignoring medical marijuana may result in reduced quality of care, which may in turn affect insurance payments from Medicare and Medicaid, as well as private insurers.⁵⁶

The notion of hospitals operating dispensaries comes in clear conflict with Medicare and Medicaid certification.⁵⁷ Possessing and maintaining a

51. See ILL. COMP. STAT. § 130/30 (patients are not forbidden from bringing medical marijuana in to a hospital, just from smoking it in the hospital. As a result, patients with debilitating conditions may bring consumable products in during an inpatient stay).

52. 410 ILL. COMP. STAT. 130/30(a)(3)(F).

53. See David Karp et al., *Medical Record Documentation for Patient Safety and Physician Defensibility: A Handbook for Physicians and Medical Office Staff*, MED. INS. EXCH. OF CALIFORNIA 6 (Jan. 2008), available at <http://www.miec.com/Portals/0/pubs/MedicalRec.pdf> (recording a patient is using medical cannabis is not a legal issue, as it is no different than ordinary triage circumstances where a nurse may inquire and record if the patient uses alcohol, smokes or uses any substance of abuse).

54. Marcoux et al., *Medical Marijuana and Related Legal Aspects*, 38 PHARMACY & THERAPEUTICS 612, 618 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3875249/>.

55. See Karp, *supra* note 53.

56. Marcoux *supra* note 54. Failing to note a patient is using medical marijuana, like the failure to note the patient is using any drug, may provide medical complications from interactions with other substances. Currently, a total of 549 drugs have documented interactions with cannabis, seven of which have highly clinically significant interactions. *Cannabis Drug Interactions*, <http://www.drugs.com/drug-interactions/cannabis.html> (last updated Nov. 16, 2014).

57. See Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations, *supra* note 36 (certifying compliance with federal law while possessing and trafficking a controlled substance).

large amount of a controlled substance is a clear violation of federal law and a hospital pharmacy dispensing marijuana would be in violation of its DEA license.⁵⁸ However, this risk may not be enough to stop hospitals from examining the prospect of a hospital-operated dispensary. For example, Swedish Covenant Hospital recently expressed interest in operating a dispensary, given its secure pharmacy and physician population interested in patient certification.⁵⁹ Swedish Covenant Hospital's ambitions were quelled by the City's zoning restrictions.⁶⁰ Hospitals in Chicago cannot operate a dispensary if near a school, in a residential area, or a facility with a day-care center on site.⁶¹ Regardless, operating a dispensary within a hospital presents incredible risk to losing Medicare and Medicaid participation, and likely opens a door to litigation and criminal charges for the hospital, physicians, nurses, and pharmacists.⁶² Unless a hospital wishes to take the risk of future operating uncertainty and near-certain litigation, any interaction between hospital pharmacies and marijuana should be avoided.

As a final consideration, hospitals should keep in mind that medical marijuana is not reimbursed through private insurance.⁶³ So long as the substance remains on Schedule I, insurance companies are prohibited from reimbursing for the purchase of an illegal substance with "no medical value."⁶⁴ Without insurance reimbursement, very few patients may be able

58. See DRUG ENFORCEMENT AGENCY, *supra* note 46.

59. Becky Schlinkerman, *Hospital Sales of Medical Marijuana Fraught with Questions*, CHICAGO SUN TIMES (July 21, 2014), available at <http://politics.suntimes.com/article/chicago/hospital-sales-medical-marijuana-fraught-questions/mon-07212014-158am>.

60. Ted Cox, *Medical Marijuana Zoning Set by City Council Committee* DNAINFO CHICAGO. (July 29, 2014, 6:54 PM), <http://www.dnainfo.com/chicago/20140729/downtown/medical-marijuana-zoning-set-by-council-committee>.

61. *Id.*

62. Schlinkerman, *supra* note 59; DRUG ENFORCEMENT AGENCY *supra* note 39.

63. Eamon Murphy, *Why Won't Health Insurance Cover Medical Marijuana?*, STREET (Apr. 14, 2014), <http://www.thestreet.com/story/12676155/1/why-wont-health-insurance-cover-medical-marijuana.html>.

64. Michelle Andrews, *When Your State Says Yes to Medical Marijuana, but Your Insurer Says No*, NAT'L PUB. RADIO (Nov. 20, 2012, 9:38 AM), <http://www.npr.org/blogs/health/2012/11/20/165554172/when-your-state-says-yes-to-medical-marijuana-but-your-insurer-says-no>.

to afford medical marijuana in Illinois.⁶⁵ As a result, hospitals may ultimately be risking Medicare and Medicaid participation in exchange for certifying patients to use a drug they will not be able to afford in sufficient quantities.⁶⁶

V. LOOKING FORWARD

While medical cannabis' clinical usage remains confined to smoking in private residences or through consumables, pharmaceutical companies have begun to enter into the medical marijuana market.⁶⁷ For example, GW Pharmaceuticals (GW) has developed two drugs, Sativex and Epidolex.⁶⁸ These two drugs have received fast track designation by the Food and Drug Administration (FDA) and are in Phase III trials.⁶⁹ Should GW gain ap-

65. Robert McCoppin, *Medical Marijuana May Cost Patients Top Dollar*, CHI. TRIB. (Sept. 1, 2014), available at <http://www.chicagotribune.com/news/ct-medical-marijuana-cost-met-20140901-story.html#page=1>.

66. *Id.* (discussing how health insurance does not cover medical marijuana and a credit card cannot be used to purchase it. Purchasers must have the cash to afford prices ranging as high as \$500 an ounce, and may range even higher in Illinois. For a patient who may need an ounce a month, this could lead to a conservative estimate of \$6,000 a year in cash for access to the substance before taxes. Given that many suffering from the conditions covered by the Act may be unable to work or work sufficient hours to obtain sufficient cash in addition to medical expenses, access to the substance will be costly for many who need it most).

67. Bruce Kennedy, *3 Pharma Companies Investing in Cannabis-Related Treatments*, BENZINGA (Aug. 28, 2014, 10:42 AM), <http://finance.yahoo.com/news/3-pharma-companies-investing-cannabis-144217923.html> (there is developing interest in the pharmaceutical application of cannabis, marking a significant change from the previous pharmaceutical manufacturer stance); *But see* Pamela Engel, *America's Drug Companies are Bankrolling the Crusade Against Legal Weed*, BUSINESS INSIDER (Jul. 11, 2014, 10:27 AM), <http://www.businessinsider.com/police-unions-and-pharmaceutical-companies-fund-anti-marijuana-fight-2014-7> (indicating there is still substantial incentive for pharmaceuticals to not only avoid medical cannabis but to try to further prevent its legalization).

68. *GW Pharmaceuticals Announces that Sativex Receives Fast Track Designation from FDA in Cancer Pain*, GW PHARM., (Apr. 28, 2014), <http://www.gwpharm.com/GW%20Pharmaceuticals%20Announces%20that%20Sativex%20Receives%20Fast%20Track%20Designation%20from%20FDA%20in%20Cancer%20Pain.aspx> [hereinafter *Sativex*]; *GW Pharmaceuticals Announces Epidolex Receives Fast Track Designation from FDA for the Treatment of Dravet Syndrome*, GW PHARM., (June 6, 2014), <http://www.gwpharm.com/GW%20Pharmaceuticals%20Announces%20Epidolex%20Receives%20Fast%20Track%20Designation%20from%20FDA%20for%20the%20Treatment%20of%20Dravet%20Syndrome.aspx> [hereinafter *Epidolex*].

69. *Sativex*, *supra* note 69; *Epidolex*, *supra* note 69; see NAT'L INST. OF HEALTH, FAQ QUESTION: WHAT ARE CLINICAL TRIAL PHASES?, <http://www.nlm.nih.gov/services/ctphases.html> (last updated Apr. 18, 2008) (explaining Phase III trials are clinical trials where a drug is given to a large sample to confirm the drug is both safe and effective to

approval from the FDA for either drug, the DEA would be required to reconsider marijuana's scheduling as a Schedule I substance.⁷⁰ If marijuana were removed from Schedule I, physicians could not only certify, but also prescribe the substance.⁷¹ Whether the drug would be reimbursable under Part D of Medicare may be up to the discretion of the federal government, and private insurance may hesitate as well.⁷² However, with the possibility of a pharmaceutical company demonstrating some forms of medical marijuana to be safe and effective, insurance reimbursement for certain medical marijuana-based treatments may be considered in the near future⁷³

Hospitals willing to take on the risk presented by certifying patients or maintaining a dispensary must remember that the risk calculation is entirely politically dependent.⁷⁴ In 2013, the Department of Justice (DOJ) issued a memorandum that it would not challenge state laws legalizing medical marijuana.⁷⁵ Additionally, the House of Representatives recently voted to defund the DOJ, including the DEA, for any activity with the purpose of interfering with medical marijuana operations legalized by States.⁷⁶ However,

meet the FDAs approval requirements for new drug applications).

70. See Schedules of Controlled Substances, 21 U.S.C.A. § 812(b)(1) (West 2014).

71. See *id.*

72. Michelle Andrews, *Advocates of Medical Marijuana Face Another Hurdle: Insurance Coverage*, KAISER HEALTH NEWS (Nov. 19, 2012), <http://kaiserhealthnews.org/news/112012-michelle-andrews-on-medical-marijuana/> (stating insurance companies “want to see stronger scientific evidence that marijuana is as safe and effective as other drugs to treat pain or nausea.”).

73. See *id.*

74. Sean Sullivan & Scott Clement, *Public Support for Medical Marijuana is Reaching New Highs. Why do Republican 2016 Hopefuls find the Idea a Buzzkill?*, THE WASHINGTON POST (Aug. 15, 2014), <http://www.washingtonpost.com/blogs/post-politics/wp/2014/08/15/public-support-for-medical-marijuana-is-reaching-new-highs-why-do-republicans-2016-hopefuls-find-the-idea-a-buzzkill/> (discussing while public opinion in favor of legalizing marijuana medicinally remains around eighty percent, Republican candidates are very mixed on their support in any change in position. Many of these leaders come from states who have legalized the substance medically or have legislation in motion to legalize, raising questions as to whether their opinion will shift depending on how their state votes).

75. Kevin Johnson & Raju Chbeium, *Justice Dept. Won't Challenge State Marijuana Laws*, USA TODAY (Aug. 29, 2013), <http://www.usatoday.com/story/news/nation/2013/08/29/justice-medical-marijuana-laws/2727605/>.

76. John Ingold, *Impact of U.S. House Vote on Medical Marijuana Enforcement Unclear*, DENVER POST (May 31, 2014), http://www.denverpost.com/marijuana/ci_

with Attorney General Eric Holder resigning from office and the 2016 elections looming, medical marijuana may soon be brought to the national stage for a political verdict.⁷⁷ Given the anecdotal evidence of success, as well as the continuing trend towards state legalization for medical purposes, it is unlikely the medical legalization push does not reach Congress' doorstep in the next five years.

VI. CONCLUSION

Medical marijuana may have substantial benefits for patients, but the risks it presents for hospitals negate some of the positive outlook for medical marijuana. Clinical administration of medical marijuana puts a hospital's Medicare and Medicaid status at risk. Without the ability to participate in Medicare and Medicaid, a hospital would be unable to continue to exist. The risk of jeopardizing Medicare and Medicaid participation remains high given the DEA position on marijuana, and hospitals must remain wary of this risk. Until the Seventh Circuit addresses whether certification is the equivalent to prescribing, it is in a hospital's best interest to implement clear policies on how it wishes for staff and community physicians to approach requests from patients.

Furthermore, it is imperative that Illinois hospitals communicate with all clinical staff on how to approach issues stemming from patients seeking certification. Most importantly, the hospital must determine how it intends to have nurses and other clinical staff handle patients bringing in their own medical marijuana to the inpatient setting. Until the federal government reconciles the current conflict in law resulting from the growing number of

25869675/impact-u-s-house-vote-medical-marijuana-enforcement.

77. Johnson, *supra* note 75; see also Conor Friedersdorf, *The Other Big Election 2014 Losers: Marijuana Prohibitionists*, ATLANTIC MONTHLY (Nov. 5, 2014 6:26 AM), <http://www.theatlantic.com/politics/archive/2014/11/the-biggest-election-2014-winner-marijuana/382393/> (discussing 2014 midterm election outcomes for several states with marijuana on the ballot. Oregon, Alaska, and Washington, D.C. all voted to legalize marijuana. A Florida constitutional amendment legalizing medicinal marijuana failed, but achieved fifty-eight of the sixty percent of the vote needed for the amendment to pass).

states legalizing medical marijuana, hospitals are best suited to proceed with caution and avoid the introduction of marijuana into clinical practice.

Value-Based Insurance Design Viability in the
Illinois Exchange

*Joseph Willuweit**

I. INTRODUCTION

State health insurance exchanges are a core, yet controversial, element of healthcare reform and have been at the forefront of both political and policy debates since the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010. States that run their own exchanges or partnership exchanges jointly with the federal government have a degree of latitude in the design and implementation of their exchanges.¹ As a result, state exchanges have the opportunity to be test sites for various insurance policy reform efforts.²

This article argues that the state of Illinois and Illinois insurance companies should incorporate elements of value-based insurance design (VBID) into the state exchange as well as Medicaid expansion. Part II provides background information on VBID and the potential benefits of its implementation. Part III provides an overview of the state exchange and Medicaid expansion in Illinois. Part IV argues why VBID should be adopted as part of Illinois health reform efforts and Part V outlines possible methods by which this may be accomplished.

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1. STAFF OF H.R. COMM. ON THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE STUDY 97TH CONG., REP: FINDINGS OF THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE STUDY COMMITTEE 7 (COMM. PRINT 2011), *available at* <http://cgfa.ilga.gov/Upload/FindingsOfILLegisHealthInsuranceExchangeStudyCommitteeSB1555.pdf>.

2. *See id.* at 17 (describing “the issues regarding the implementation and establishment of a health benefits exchange for the State of Illinois.”).

II. VBID AND POTENTIAL BENEFITS OF IMPLEMENTATION

VBID seeks to “align patients’ out-of-pocket costs, such as copays and deductibles, with the value of health services” in an effort to improve health outcomes while simultaneously lowering healthcare costs.³ In a broad sense, VBID aims to increase the usage of “high-value” medications and medical procedures, such as insulin and statins, which provide substantial clinical benefits relative to costs.⁴ These efforts often target chronic diseases to reduce the probability of adverse events in the future that are significantly more expensive than the cost of prevention-related services and medications.⁵ A simple example to illustrate this concept is when an insurance policy eliminates copayments on a heart medication in order to induce the beneficiary to comply with its treatment program, and therefore avoid a heart attack and a costly trip to the emergency room.⁶

VBID relies on two main principles. The first is that patients should not be discouraged through cost sharing for taking advantage of cost-effective care that can significantly improve their health.⁷ The second is that value in health care should be signaled to consumers.⁸ For example, non-cost effective care such as name-brand prescription drugs or unnecessary procedures should be eliminated from benefits packages or have increased cost sharing.

3. *Value-Based Insurance Design can drive innovation in Health Insurance Exchanges*, UNIV. OF MICH. CTR. FOR VALUE-BASED INS. DESIGN 1, available at https://www.staterforum.org/system/files/principles_for_vbid_in_exchanges_final.pdf (last visited Sept. 27, 2014) [hereinafter *Value-Based Insurance Design*].

4. Michael E. Chernew et al., *Evidence that Value-Based Insurance can be Effective*, 29 HEALTH AFF. 530, 530 (2010).

5. *Id.* at 531.

6. Niteesh K. Choudhry, et al. *Full Coverage For Preventive Medications After Myocardial Infarction*. 365 NEW ENG. J. MED., 2088, 2096 (2011) (finding that the elimination of copayments for statins, beta-blockers and other common heart medication increased medication adherence and reduced the rates of first major vascular events and total major vascular events or revascularization).

7. Sarah Thomson et al., *Value-Based Cost Sharing in the United States and Elsewhere can Increase Patients’ Use of High-Value Goods and Services*, 32 HEALTH AFF. 704, 704 (2013) (cost sharing refers to the share of costs covered under an insurance policy that the patient pays out-of-pocket, including deductibles, coinsurance and copayments).

8. *Id.*

Existing VBID plans have sought to achieve these aims in different ways. One method is to base reduced cost sharing on clinical criteria.⁹ Under this approach, patients suffering from specific conditions would be targeted for reduced copayments.¹⁰ For instance, diabetics would receive free secondary prevention treatment such as eye and foot exams.¹¹ Alternatively, some plans have eliminated copayments on drugs that treat common chronic conditions such as hypertension.¹² Another structure in which VBID may be utilized is through the use of copayment tiers based on value that is similar to copayment tiers that are tied to the cost of prescription drugs (generic, preferred name-brand, name-brand).¹³

While the cost-effectiveness of treatment may be achieved through the implementation of VBID principles, cost savings through VBID are the ultimate goal for employers and insurers.¹⁴ This issue will be further addressed below.

III. LANDSCAPE OF THE ILLINOIS EXCHANGE AND MEDICAID EXPANSION

Illinois currently has a partnership-exchange, referred to as the Illinois Health Benefits Exchange, which is jointly run by the state and federal government.¹⁵ Illinois plans to transition to a fully state-run exchange in 2015.¹⁶ The Illinois Health Benefits Exchange law created the exchange in

9. Niteesh K. Choudhry et al., *Assessing the Evidence for Value-Based Insurance Design*, 29 HEALTH AFF. 1988, 1990 (2010) (noting that clinical criteria may mean a triggering event, for example a patient who has suffered a myocardial infarction).

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.* (describing an insurance plan where copayments for medications used to treat chronic conditions were reduced by 100 percent for generic, 50 percent for preferred name-brand, and 25 percent for name-brand).

14. Chernew et al., *supra* note 4, at 531.

15. *State Marketplace Profiles: Illinois*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/health-reform/state-profile/state-exchange-profiles-illinois> (last updated Oct. 15, 2013).

16. *Id.* (positing that state-run exchanges give the state more flexibility and control in deciding what insurers may participate, designing plan benefits, and performing local outreach and promotion).

2011, which functions as a marketplace for individuals and businesses with fewer than fifty employees.¹⁷ One of the hallmarks of the PPACA is that in order for a health insurance plan to be adequate and able to be sold on the exchange it must provide a minimum set of “essential health benefits” that each state may tailor to its specific goals.¹⁸ Illinois chose the BlueCross BlueShield of Illinois BlueAdvantage small group plan as its essential health benefits benchmark.¹⁹

Health Care Service Corporation, the owner of Blue Cross Blue Shield of Illinois, is the largest health carrier in Illinois and has 49% of the total market share for health insurance, representing the second highest level of market concentration among the ten largest states.²⁰ As of 2011, it was estimated that 52% of Illinoisans were covered by employer-sponsored insurance, 4% by the individual market, 20% by Medicaid, 12% by Medicare and other public programs, and 12% were uninsured.²¹ The most important factors Illinois residents consider in selecting an insurance plan are out-of-pocket costs (copayments, deductibles, and premiums), accessibility of providers in network, and coverage of prescription drugs.²² The regulatory framework for new insurance carrier entrants into the Illinois health insurance market-

17. Illinois Health Benefits Exchange Law, 215 ILL. COMP. STAT. 122/5-5 (2011).

18. 42 U.S.C. § 18022 (“Essential health benefits” are the federally mandated package of items and services required of insurance plans for minimum coverage and include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care).

19. *State Marketplace Profiles: Illinois*, *supra* note 15 (noting that this is a relatively lean plan, covering Illinois-mandated services such as treatment for autism and infertility but imposing, for example, a \$1,000 annual limit on chiropractic care as well as offering no coverage for vision or hearing exams for adults).

20. DELOITTE, REVIEW OF THE CURRENT ILLINOIS HEALTH COVERAGE MARKETPLACE: BACKGROUND RESEARCH REPORT 7 (2011), *available at* http://insurance.illinois.gov/hiric/resources/ILBackgrounResearchFinalReport_September2011.pdf (noting that Illinois has a high market concentration for health insurance: the top two carriers in the state have 63% of the total membership).

21. *Id.* at 5.

22. *Id.* at 52.

place presents no unusual barriers to entry when compared to other states.²³

Presently, Illinois has not determined the structure and organization of its state-run exchange; however, other states follow either the “market organizer” or “market developer” models.²⁴ Illinois legislators will face a choice whether to be hands-off and let market forces dominate the organization of the insurance plans on the exchange or take a more active role by regulating and developing the various plans.²⁵ The Illinois Health Benefits Exchange Legislative Study Committee has identified the following goals for the exchange: the exchange should encourage competition among health insurers, seek enhanced value of health insurance products, and encourage insurers to make their best products available.²⁶ Further, the exchange should strive to gain volume in order to be more attractive to health insurers and encourage competition in order to reduce the demand for government intervention.²⁷

Finally, the improved health insurance environment fostered by the exchange should make Illinois more attractive to employers and the authorizing legislation to create an exchange in Illinois should provide control over plan certification so that plan design on the exchange is not cabined by federal requirements.²⁸ All of these goals for the Illinois health insurance marketplace have potential ramifications for the introduction of VBID principles into the exchange. Furthermore, the Illinois Department of Insurance has announced that ten insurance carriers have applied to offer 504 new Qualified Health Plans in 2015 that meet the state’s essential health benefits

23. *Id.* at 82 (stating that the licensing and HMO approval process is not excessively burdensome, product approval and rate review does not significantly limit the attractiveness of the Illinois marketplace, and that consumer protections, rating and underwriting restrictions are consistent with those in other states).

24. STAFF OF H.R. COMM. ON THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE STUDY, *supra* note 1, at 7-8 (In a market organizer model the exchange would have no role in bargaining with insurers or otherwise attempting to influence the insurance market whereas in a market developer model the exchange would pursue competitive plans, leveraging its power to ensure the “best” deal for consumers).

25. *Id.* at 8.

26. *Id.* at 9-10.

27. *Id.*

28. *Id.*

requirement through the exchange.²⁹

Illinois further expanded its Medicaid program to include “PPACA adults” in 2014.³⁰ Numerous statutory changes made within the past few years affect the Illinois Medicaid program, including legislation requiring that at least half of Medicaid recipients be enrolled in risk-based, coordinated care systems by 2015.³¹ Additionally, a number of federal grants were awarded to Illinois to fund efforts to improve the delivery of Medicaid services.³² Furthermore, in March of 2014 Illinois submitted a Medicaid 1115 waiver request, called *Path to Transformation*, to the Centers for Medicare and Medicaid Services (CMS) for approval.³³ If approved, the 1115 waiver authorizes a demonstration or pilot program for various Medicaid reform initiatives.³⁴ It may be possible for Illinois to incorporate VBID principles within this framework of reform because such waiver allows the state to receive matching federal funds for spending that is not currently allowed un-

29. Press Release, State of Ill. Dept. of Ins., DOI Announces Ten Issuers Apply to Offer 504 Qualified Health Plans for Year Two of Illinois Health Insurance Marketplace (June 12, 2014), *available at* <http://www3.illinois.gov/pressreleases/ShowPressRelease.cfm?SubjectID=2&RecNum=123>

30 (a Qualified Health Plan is a plan that meets the federally mandated essential health benefits plus any other minimum benefits required by the Illinois exchange).

30. Illinois Medicaid Moving Forward in 2014, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/by-state/illinois.html> (last visited Oct. 22, 2014) (describing “PPACA adults” as those low-income, healthy adults who now qualify for Medicaid outside of the traditional categories as a result of the PPACA Medicaid expansion).

31. *Illinois Alliance for Health Innovation Plan*, ALLIANCE FOR HEALTH 1 (Dec. 30, 2013), *available at* <http://www2.illinois.gov/gov/healthcarereform/Documents/Alliance/Alliance%20011614.pdf> (describing a “risk-based coordinated care system” as an integrated delivery system consisting of a broad network of providers including primary care physicians, behavioral health professionals, and long-term care facilities, amongst others, linked by a redesigned payment structure to support clinical integration between those providers by basing reimbursement on population health).

32. *Id.* (including a \$2 million six-month planning grant from the Center for Medicare and Medicaid Innovation intended to help Illinois achieve the “triple aim” of improved health status, improved efficiency of clinical care, and cost reduction of care).

33. *FAQ on 1115 Waiver Application*, ILL. GOVERNOR’S OFFICE OF HEALTH INNOVATION & TRANSFORMATION 1, <http://www2.illinois.gov/gov/healthcarereform/Documents/GOHIT/FINAL%20FAQs%20about%20the%201115%20Waiver%20Application.pdf> (last visited Sep. 26, 2014).

34. *Id.*

der the Medicaid rules.³⁵

IV. VBID SHOULD BE ADOPTED IN ILLINOIS HEALTHCARE REFORM EFFORTS

One significant reason for Illinois and insurance companies within the state to experiment with VBID is that it is particularly well suited to the management of chronic conditions.³⁶ Chronic diseases like heart disease, cancer, stroke, and diabetes are responsible for seven out of ten deaths every year and account for 75% of healthcare spending in the United States.³⁷ Around half of all American adults have one or more chronic health conditions and one in four adults have two or more chronic health conditions.³⁸ Additionally, more than one third of adults were characterized as obese in 2010.³⁹ Chronic conditions are the “most common, costly, and preventable of all health problems,”⁴⁰ and therefore implementing VBID to better manage chronic conditions makes clinical and economic sense.

Behavioral economics research has shown, however, that consumers of health care are not adept at making decisions that pit present expenditures against future catastrophic medical problems.⁴¹ The inability to make efficient health care choices is further exacerbated by the daunting complexity of modern health insurance, where even a simple explanation of benefits contains many terms and policies with which a broad swath of consumers are unfamiliar and have no frame of reference for comparison or understanding. This is deeply problematic because management of chronic condi-

35. *Id.*

36. Chernew et al., *supra* note 4, at 531.

37. *The Affordable Care Act's Prevention and Public Health Fund in Your State*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/healthcare/facts/bystate/publichealth/ppht-map.html> (last updated Feb. 14, 2012).

38. *Chronic Disease Prevention and Health Promotion*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/chronicdisease/overview/index.htm> (last updated May 9, 2014).

39. *Id.*

40. *Id.*

41. Daniel Young, *Curing What Ails Us: How the Lessons of Behavioral Economics Can Improve Health Care Markets*, 30 YALE L. & POL'Y REV. 461, 469 (2012).

tions falls largely on the choices of patients to seek initial treatment or to comply with their current treatment plans.⁴² Behavioral health experts have suggested that simplifying the process of purchasing insurance on state exchanges and offering comprehensible, “apples to apples” comparisons may improve the efficiency of the consumer’s health care choices by directing them toward plans with benefits they require.⁴³ This concept coincides with the “signaling” principle of VBID, which proposes that the value of a treatment should be made apparent to consumers so that they can distinguish high-value from low-value care.⁴⁴ An example is the use of reference pricing, where an insurer sets a maximum reimbursement, the reference price, for a cluster of similar drugs and the patient pays the difference if they choose a drug above the reference price.⁴⁵ As a result, consumers are steered toward lower cost substitutes. Similarly, if health insurance plans incorporated VBID principles such as providing benefit incentives to individuals to better manage their chronic conditions, it may lead consumers to purchase those plans, resulting not only in improved health outcomes but cost savings as well.⁴⁶

In addition to its promising application for the improved management of costly chronic conditions, Illinois insurance companies should consider VBID because it has been successfully implemented in a number of test settings and shown benefits to insurers in certain circumstances.⁴⁷ Test settings for VBID have largely been in the commercial sector, where private insurers such as Blue Cross and Blue Shield, Aetna, and United Healthcare have

42. Chernew et al., *supra* note 5, at 530.

43. Young, *supra* note 41, at 495.

44. Thomson et al., *supra* note 7, at 704.

45. *Id.* at 706.

46. Chernew et al., *supra* note 5, at 531.

47. See Michael E. Chernew et al., *Implementing Value Based Insurance Design in the Medicare Advantage Program*, VBID HEALTH 6-7 (May 2013), available at http://www.vbidhealth.com/docs/ImplementingVBIDintheMedicareAdvantageProgram_May2013.pdf.

been at the forefront of value-based experimentation.⁴⁸ Blue Cross Blue Shield of North Carolina experienced increased adherence to diabetes control medications when it eliminated or reduced copayments for both generic and brand name drugs.⁴⁹ Also, United Healthcare and Aetna used condition-specific programs to target patients with chronic conditions and experienced positive results.⁵⁰ The Oregon Public Employees' Benefit Board is another example of the successful integration of VBID principles into a benefit program.⁵¹ The Board coupled reduced cost sharing for chronic disease management and preventive services with increased cost sharing for "over-used or preference-sensitive services of low value," and saw more favorable usage rates for the procedures they targeted.⁵²

A comprehensive example of an entity successfully utilizing VBID is the Connecticut Health Enhancement Program (HEP) for state employees.⁵³ Launched in 2011, the HEP "incorporates clinically-nuanced elements of VBID, eliminating barriers to specified evidence-based clinical services based on beneficiary demographics and medical history."⁵⁴ The marriage of accountability and incentives for participants has proved promising as monthly primary care visits have increased, specialty care visits have decreased, and monthly emergency room visits have fallen.⁵⁵ These results, if repeatable in the Illinois market, offer evidence that VBID can be a viable

48. Thomson et al., *supra* note 7, at 708.

49. Chernew et al., *supra* note 47, at 6.

50. *Id.* at 6 (citing increased adherence to evidence based guidelines, improved clinical outcomes, and decreased disease-specific spending for patients with asthma and heart disease).

51. *Id.*

52. *Id.* at 6-7 (including elective surgery for back pain, arthroscopies, and advanced imaging as examples of over-used or preference-sensitive services).

53. *V-Bid in Action: A Profile of Connecticut's Health Enhancement Program*, UNIV. OF MICH. CTR. FOR VALUE-BASED INS. DESIGN, 1 (Jan. 2013), available at http://www.shadac.org/files/shadac/publications/V-BID%20brief_CT%20HEP%20final.pdf.

54. *Id.*

55. *Id.* at 2 (reporting that after the implementation of this program monthly primary care visits have increased from about 12,000 to about 21,000, monthly specialty care visits have decreased from about 24,000 to about 19,000 and emergency room visits have fallen from about 3,500 to 2,700).

element of health insurance plans.

Overall, the possibility of VBID to improve clinical outcomes, reducing costs for chronic conditions, and its successful implementation in test settings support the contention that Illinois and insurance companies within the state should incorporate VBID principles through the state Exchange.

V. HOW ELEMENTS OF VBID MAY BE IMPLEMENTED IN ILLINOIS

A confluence of factors support the notion that the best time to implement VBID in the Illinois Health Benefit Exchange is now. A study by Mercer in 2010 showed that 81% of large employers plan to incorporate VBID into their employee benefit plans in the near future.⁵⁶ Furthermore, one third of U.S. employers plan to move their workers to a private exchange in the next few years.⁵⁷

The best time to introduce innovation into a system is when it is in flux, as is the current health insurance market in Illinois. From a challenge to the status quo emerges the opportunity for innovation that may not have been previously possible and the potential to benefit payers who take advantage of the changing health insurance structure. As a result of the planned expansion of the Illinois exchange, the state and Illinois insurance companies have a window to apply VBID principles, thereby adding value to the system. For example, incorporating a “signaling” function into the exchange may, through consumer choice, synchronize insurance design and patient needs in a manner impossible before the exchange, creating a more efficient healthcare system. According to the University of Michigan Center for Value-Based Insurance Design (the Center), VBID can add value to state exchanges by “encourag[ing] smarter health care spending in order to provide

56. *Value-Based Insurance Design*, *supra* note 3.

57. Caroline Chen, *Employers Turn to Private Health Exchanges to Cut Costs*, BLOOMBERG (Feb. 19, 2014), <http://www.bloomberg.com/news/2014-02-19/employers-turning-to-private-health-exchange-to-cut-costs.html> (noting that private exchanges are health insurance marketplaces geared more towards large employers who contract with the insurers on the exchange who then offer a limited range of options to employees).

comprehensive health benefits at lower cost, promot[ing] access to needed services and higher quality of care, and increas[ing] the capacity to integrate new clinical evidence and standards by providing appropriate incentives.”⁵⁸

To accomplish these ends, the Center recommends that states like Illinois avoid over-prescriptive cost-sharing rules, maintain flexibility and limit mandates in benefit designs, and ensure that quality ratings for health plans incorporate value-based principles.⁵⁹ These principles can be broken down into more concrete suggestions. For example, tying copayments to clinical value will encourage providers to adhere to best practices and promote the use of high value services.⁶⁰ Also, because VBID plans tend to increase the use of high-value services due to lower up-front cost, actuarial values may be higher than usual.⁶¹ Therefore, the exchange should be wary of mandating too many benefits in order to prevent “pricing out” VBID plans from the bronze and silver tier due to high actuarial value.⁶² Furthermore, the quality rating tools on the exchange website should inform consumers of the potential benefits of VBID plans.⁶³

Within the next year, Illinois will make a decision as to which model of state-run exchange it wants to implement when it fully takes over operation of the exchange from the federal government.⁶⁴ This will be an opportune time to open the exchange to plans that incorporate VBID principles and encourage private insurance companies to experiment with value-based policies. Although empirical studies show the efficiency of VBID plans, the

58. *Value-Based Insurance Design*, *supra* note 3.

59. *Id.* at 1-2.

60. *Id.* at 1.

61. *Id.* at 2 (defining the actuarial value of a health insurance plan as the percentage of total average costs for covered benefits that the plan will pay for). *See also*, Actuarial Value, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/actuarial-value/> (last visited Oct. 22, 2014).

62. *Value-Based Insurance Design*, *supra* note 3 (describing “pricing out” as a plan paying for too large a percentage of the covered benefits vis a vis the beneficiary. Actuarial value under PPACA is set at 60% of costs for a bronze plan and 70% for a silver plan.).

63. *Id.*

64. *State Marketplace Profiles: Illinois*, *supra* note 15.

gains may not be visible in the short term and administrative costs can be high, possibly discouraging insurers and employers from utilizing VBID.⁶⁵ Additionally, VBID programs may need to be in effect for several years to achieve cost savings and/or specifically target high-risk populations or groups for whom cost is an important aspect of health care consumption.⁶⁶ Given this uncertainty, while VBID may pay off for private insurers over time, the profit-seeking nature of the commercial sector may make it more efficacious for Illinois to incorporate VBID into its Medicaid expansion effort.

Currently, the Illinois Alliance for Health, a group composed of health policy makers, health care providers, insurers, payers, public health professionals, small and large businesses, and community development advocates, has received a substantial federal grant to develop an Innovation Plan to improve Medicaid services in Illinois.⁶⁷ Two primary components of the plan are “building a Medicaid Innovation Model that has consumer empowerment at its core” and “redefining roles and responsibilities for all providers, plans, and payers.”⁶⁸ The integration of VBID into Illinois Medicaid reform has the potential to help achieve these goals.

Although Medicaid is not an insurance plan sold on the exchange, the exchange is the point of entry for new Medicaid enrollees.⁶⁹ Illinois’ 1115 waiver offers the opportunity to use Medicaid as a testing ground for elements of VBID. The waiver would allow Illinois much more latitude in designing its Medicaid benefits.⁷⁰ Medicaid offers an interesting alternative to commercial insurers. For instance, Medicaid has a ready-made pool of high-

65. Thomson et al., *supra* note 7, at 709.

66. Matthew L. Maciejewski et al., *Value-Based Insurance Design Program in North Carolina Increased Medication Adherence but was Not Cost Neutral*, 33 HEALTH AFF. 300, 306 (2010).

67. *Illinois Alliance for Health Innovation Plan*, *supra* note 31.

68. *Id.* at 3.

69. *State Marketplace Profiles: Illinois*, *supra* note 15.

70. *FAQ on 1115 Waiver Application*, *supra* note 33, at 1.

risk populations and populations for who cost may limit health care consumption. Furthermore, certain Medicaid beneficiaries may be more likely to remain on Medicaid than employees on private insurance plans who may frequently change jobs and therefore insurance plans.⁷¹ Incorporating VBID into Medicaid expansion would allow the positive effects of VBID to be observed over a longer period of time.

VI. CONCLUSION

As a result of the PPACA, state health insurance exchanges have the opportunity to be test sites for various insurance policy reform efforts. The emphasis VBID places on the increased use of high-value services and medications makes it a policy proposal that has the potential to both lower costs and improve clinical outcomes, particularly in the area of chronic disease management. Therefore, Illinois and insurance companies within the state should incorporate elements of VBID into the state exchange as well as Medicaid expansion. The state and private insurance companies can look to successful VBID-based programs around the country for direction in implementing similar policies in Illinois. Illinois' shift to a state-run exchange allows it greater latitude in promoting VBID principles and in working with insurers to provide plans that incorporate those principles. VBID has strong proponents in the academic and policy arenas in part because it makes so much sense in theory yet has not been widely-enough implemented to come into disfavor. If Illinois adopts VBID in its state exchange either through private insurers or Medicaid expansion, there is not only the possibility that health care costs will fall and clinical outcomes improve, there is the potential for Illinois to emerge as a national leader in health care reform policy.

71. See Choudhry et al., *supra* note 9, at 1993.

Long-Term Care in Illinois: Illinois's Need for
Community-Based Care in an Institutional-Focused
System

*Elise Robie**

I. INTRODUCTION

With an aging population of baby-boomers and major changes to health care payment and policy over the last several years, long-term care has come to the forefront of the health care discussion.¹ On July 22, 2013, the governor of Illinois expanded the eligibility criteria for Medicaid under Public Act 098-0104, which effectively implemented the Affordable Care Act (ACA) in Illinois.² In signing Public Act 098-0104 into law, Illinois expanded the number of individuals eligible to receive Medicaid, which would theoretically increase the number of Illinois residents able to access and receive long-term care.³ However, eligibility does not equate to receipt

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1. Naomi Freundlich, *Long-Term Care: What Are the Issues?*, ROBERT WOOD JOHNSON FOUND., 4 (Feb. 2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf410654 (“In 2010, 40 million people age 65 and older accounted for 13 percent of the U.S. population. This number is expected to jump to 72 million people of 19 percent of the population by 2030. Even more significant, the number of people age 85 or older— who are most likely to need long-term care— is projected to grow from 5.5 million in 2010 to 8.7 million in 2030 and 19 million by 2050.”).

2. Specialized Mental Health Rehabilitation Act of 2013, Pub. L. No. 098-0104, <http://www2.illinois.gov/hfs/SiteCollectionDocuments/098-0104.pdf>; <http://12.43.67.2/legislation/billstatus.asp?DocNum=0026&GAID=12&GA=98&DocTypeID=SB&LegID=68456&SessionID=85&SpecSess=>. *National Federation of Independent Business v. Sebelius* made the ACA's requirement that states expand Medicaid optional. Gerry Smolka, Megan Multack, & Carlos Figueiredo, *Effect of Health Reform for 50- to 64-Year Olds*, AARP PUBLIC POLICY INST., 10 n.17 (Dec. 2013).

3. Under the ACA, Medicaid eligibility was expanded to adults ages 19-64 without a disability or dependent children and with incomes at or below 138% of the Federal Poverty Level. *Answers to Frequently Asked Questions: The Affordable Care Act in Illinois*, ILL.

of care, and many Illinois residents remain under the alarming misconception that Medicare and Medicaid programs will cover all of their long-term care needs.⁴ This article will argue that despite the expansion of Medicaid and Illinois's increasing focus on community-based care over institutional care, the delivery and expense of long-term care remains a challenge and must continue to be addressed, especially with the increasingly aging population. While focusing on developing the infrastructure of community-based care over institutional care, Illinois must also educate its residents about long-term care payment options and encourage long-term care planning so it can work towards enabling residents to actually receive the care they need rather than merely expanding eligibility. Unless Illinois develops more community-based services and policies to support more cost-effective administration of long-term care, and unless Illinois helps residents to educate themselves in planning for and utilizing more affordable long-term care, residents will continue to be trapped in expensive institutional care, burdening both the state and themselves.

II. LONG-TERM CARE FRAMEWORK

Long-term care includes both medical and non-medical services that help disabled or elderly individuals meet their needs on a daily basis.⁵ This type of care encompasses a wide range of support administered by both paid and unpaid providers to help the individual receiving care maintain his or her lifestyle and function to the best of his or her ability.⁶ Individuals with

DEP'T OF HEALTHCARE & FAMILY SERVS., 10 (Nov. 26, 2013).

4. Health Policy Brief, *The CLASS Act. The long-term care insurance program created by the Affordable Care Act will be reshaped to address concerns about solvency*, ROBERT WOOD JOHNSON FOUND., 2 (May 21, 2011), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_46.pdf.

5. See ROBYN STONE, LONG TERM CARE FOR ELDERLY 11 (Kathleen Courier et al. eds., 2011) ("Rather, it is an array of personal care, health care, and social services and supports provided in various settings over a sustained period to persons with chronic conditions and functional limitations.").

6. ROBYN STONE, HANDBOOK OF AGING AND THE SOCIAL SCIENCES 397 (Robert H. Binstock & Linda K. George, Academic Press 6th ed., 2006).

long-term care needs may require assistance with “instrumental activities of daily living (IADLs),” like shopping and transportation, or even “basic activities of daily living (ADLs),” such as eating and bathing.⁷ Long-term care also includes the utilization of assistive devices, technology, and home modifications.⁸ Frequently, family members act as the primary providers and decision-makers for the individual in long-term care and benefit equally from support by paid caregivers or long-term care interventions because additional support helps to alleviate the burden placed upon them.⁹ Long-term care may be provided in institutional settings, predominantly provided by nursing homes, or in home- and community-based settings.¹⁰ Home- and community-based services provide the individual assistance with ADLs in various settings, generally such that the individual is able to stay in his or her home.¹¹ Home- and community-based services may be administered in the individual’s own home, assisted living facility, adult foster home, or other supportive housing.¹²

Approximately seventy percent of individuals over the age of sixty-five

7. STONE, *supra* note 5, at 2-3 (“Services provide assistance with basic activities of daily living (ADLs)—dressing, bathing, toileting, eating, and getting in and out of bed or chairs— as well as help with instrumental activities of daily living (IADLs), including household chores like meal preparation and cleaning; life management tasks, such as shopping, money management and medication management; and transportation.”).

8. These assistive devices and technologies include: canes, walkers, wheelchairs, computerized medication reminders, electronic monitoring systems to aid dementia patients, ramps, grab bars, among other things. *Id.*

9. STONE, *supra* note 6, at 397 (“It frequently involves intense participation wives and adult daughters, as providers and decision makers. Families are often equal beneficiaries of long-term care interventions, because care and supports provided by paid caregivers to the older person who is disabled are an important respite for the family caregiver.” (citation omitted)).

10. Nelda McCall, *Long Term Care: Definition, Demand, Cost, and Financing*, 4, 10, available at <http://www.ache.org/pubs/1mccall.pdf>.

11. SUSAN C. REINHARD, ET AL., *RAISING EXPECTATIONS: A STATE SCORECARD ON LONG-TERM SERVICES AND SUPPORTS FOR OLDER ADULTS, PEOPLE WITH PHYSICAL DISABILITIES, AND FAMILY CAREGIVERS* 20, 112 (2d ed., 2014). (“Services that are designed to support community living and delay or prevent admission to an institution for people with various disabilities [False] HCBS can include personal care (help with ADLs), transportation, shopping and meal preparation, home health aides, adult day services, and homemaker services. Assistance with managing medications or money may be provided.”).

12. *Id.*

will need long-term care at some point in their lives.¹³ Moreover, individuals in need of long-term care are more likely than their peers who do not need long-term care to require medical care for both acute and chronic medical conditions.¹⁴ Of the ten million American individuals in need of long-term care, roughly fifty percent are over sixty-five years old, and roughly fifty percent are under sixty-five years old with disabilities.¹⁵ Individuals under the age of sixty-five with long-term care needs include children with intellectual and developmental disabilities, individuals with spinal cord injuries, traumatic brain injuries, or suffering mental illness, to name a few.¹⁶ While an increasing portion of individuals receiving long-term care require on-going treatment for medically complex health conditions or loss of cognitive capacity, long-term care also encompasses individuals that require rehabilitation or “post-acute care” for a short period of time following hospitalization.¹⁷

III. PAYMENT OPTIONS FOR LONG-TERM CARE IN ILLINOIS

Individuals pay for long-term care with a combination of federal, state, and private funding.¹⁸ In Illinois, there are five primary avenues to pay for long-term care: private pay, long-term care insurance, veteran’s benefits

13. *Medicare & You*, CTRS. FOR MEDICARE & MEDICAID SERVS., 63 <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>. See *Who Needs Care?*, U.S. DEP’T OF HEALTH AND HUMAN SERVICES, <http://longtermcare.gov/the-basics/who-needs-care/> (stating that “70% of people turning age 65 can expect to use some form of long-term care during their lives”).

14. STONE, *supra* note 6, at 13 (“The average annual Medicare expenditures for elderly people with no long-term care needs in 2005 were \$4,289. The comparable expenditures for those with one or more ADL limitations and those with three or more ADL limitations were \$14,775 and \$18,902, respectively.” (citation omitted)); See also STONE, *supra* note 5, at 398 (“Often people who need long-term care also require primary and acute care when they are sick.”).

15. According to a 2010 survey, 49.8% of people requiring long-term care were over 65 and 50.2% were under 65 with a disability. Kaiser Commission on Medicaid Facts, *Medicaid and Long-Term Care Services and Supports*, THE HENRY J. KAISER FAMILY FOUND., 1 (June 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/2186-09.pdf>.

16. *Id.*

17. STONE, *supra* note 5, at 2-3.

18. *Id.* at 41.

available for long-term care, Medicare's limited benefit, and Medicaid.¹⁹ Additionally, Illinois offers several public assistance programs that assist in supplementing Medicaid payments for long-term care: Illinois's Long-Term Care Partnership Program; Home and Community Based Waiver Programs; and Money Follows the Person.²⁰

A. *Private Pay*

The first option for Illinois residents seeking long-term care is to pay completely out of pocket. Currently, the yearly cost of care for one individual in Illinois is estimated as follows: \$43,472 - \$46,904 for home health care, \$48,600 for assisted living facilities, and \$62,050 - \$70,455 for nursing homes.²¹ Unfortunately, these exorbitant costs are out of reach for the majority of Illinois residents.²² For instance, individuals who work in the service sector for many years earning low wages are most likely unable to save for retirement and their jobs are even less likely to offer retirement or health benefits.²³ Many seniors in Illinois survive on a "modest fixed income from social security and maybe a pension."²⁴ With a minimal income, most Illinois seniors or disabled individuals cannot afford to pay for an extended institutional stay on their own without threat of poverty or re-

19. William Siebers & Zach Hesselbaum, *Paying for Long-Term Care in Illinois*, ILL. B.J. (Oct. 2012), <http://www.isba.org/ibj/2012/10/payingforlongtermcareinillinois>.

20. Illinois Long-Term Care Partnership Program Act, 215 ILL. COMP. STAT. 132/1 *et seq.* (eff. Aug. 16, 2007); Home and Community Based Services Waiver Programs, ILL. DEP'T OF HEALTHCARE AND FAMILY SERVS., <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx#HCBSwaivers>; *Pathways to Community Living*, MFP, <http://www.mfp.illinois.gov>, (last visited Sept. 28, 2014).

21. *Costs of Care in Your State*, U.S. DEP'T OF HEALTH AND HUMAN SERV., <http://longtermcare.gov/cost-of-care-results/?state=US-IL> (follow hyperlink and then select yearly).

22. Long-term care services are unaffordable for middle-income families in the United States. Nursing home costs consume well over 100 percent of the annual income of older adults. Reinhard, *supra* note 11, at 10 (reporting that nursing home costs "consume 246 percent of the median annual household income of older American adults").

23. STONE, *supra* note 6, at 101.

24. Siebers & Hesselbaum, *supra* note 19.

ceiving inadequate care.²⁵ Even the more cost-effective options of home- and community-based care may present an unsustainable drain on an individual's assets if care must be administered for a long period of time without alternative financial assistance.²⁶ By educating residents about these figures, Illinois may encourage better long-term care planning and personal research into other options, such as long-term care insurance or community services, before long-term care is needed, and the individual in need of care becomes bound to costly institutional care. If individuals are encouraged to plan better, they may be able to first utilize a community-based option and use it longer before they must resort to more costly institutional care.

B. Long-Term Care Insurance

One such way Illinois residents may plan for and fund their long-term care needs is by obtaining private long-term care insurance. Unlike Medicare, Medicaid, and typical health insurance plans, long-term care insurance provides per diem reimbursements for ADLs and is designed for long-term support of the individual beneficiary's needs.²⁷ However, according to some studies, only ten to twenty percent of the population can afford long-term care insurance, and even less actually have it.²⁸ Experts suggest a person seeking long-term insurance should have at least \$40,000 of liquid assets prior to purchasing such insurance.²⁹ Further, older couples must purchase coverage individually and pay several thousand dollars for coverage

25. STONE, *supra* note 6, at 101.

26. Reinhard, *supra* note 11, at 10 ("Home care generally is more affordable than nursing home care, allowing consumers to stretch their dollars further. But at an average of 84 percent of median income, the typical older family cannot sustain these costs for long period.").

27. *What Is Long-Term Insurance?*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., <http://longtermcare.gov/costs-how-to-pay/what-is-long-term-care-insurance/> ("Unlike traditional health insurance, long-term care insurance is designed to cover long-term services and supports, including personal and custodial care in a variety of settings such as your home, a community organization, or other facility."); *see also* Siebers & Hesselbaum, *supra* note 19.

28. *Long-Term Care: What Are the Issues?*, *supra* note 1, at 3 (estimating "7-8 percent of Americans have insurance for long-term care").

29. STONE, *supra* note 6, at 403.

each year.³⁰ According to the American Association of Retired Persons (AARP), only ten percent of adults over fifty years old have long-term insurance policies, and those who do not purchase them typically blame the high cost of such insurance.³¹ Those who are able to afford the high cost of long-term care insurance may have sixty to seventy-five percent of their benefits provided for by their carriers.³² As such, long-term insurance is not a viable option for individuals without significant savings, although it would likely prove most beneficial to those who cannot afford it because those individuals also cannot afford to pay out-of-pocket for care.³³

To promote the purchase of long-term care insurance, Illinois has participated in a long-term care insurance partnership program since 2007.³⁴ Under the Illinois Long-Term Care Partnership Program Act (Long-Term Care Partnership Act), the Department of Healthcare and Family Services and the Department of Financial and Professional Regulation provide incentives for Illinois residents to procure long-term care insurance to prevent, delay, or eliminate dependence on Medicaid.³⁵ Specifically, an insured does not have to spend-down his or her assets after exhausting the benefits of his or her policy because those assets, up to the amount of benefits received under the long-term partnership policy, are disregarded in calculating the insured's eligibility for Medicaid.³⁶ In other words, for each dollar paid for the individual under the long-term partnership policy, he or she may retain the value of that dollar above the amount he or she would need to qualify for Med-

30. *Id.*

31. Reinhard, *supra* note 11, at 10.

32. Kathleen Ujvari, *Long-Term Care Insurance: 2012 Update*, AARP PUBLIC POLICY INST., 1 (June 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/lc/2012/lc-insurance-2012-update-AARP-ppi-ltc.pdf.

33. *Id.*

34. Illinois Long-Term Care Partnership Program Act, 215 ILL. COMP. STAT. 132/1 *et seq.* (eff. Aug. 16, 2007).

35. 215 ILL. COMP. STAT. 132/5.

36. 215 ILL. COMP. STAT. 132/15(b)(1); NAT'L ASS'N OF INS. COMM'RS, *A Shopper's Guide to Long-Term Care Insurance*, 12 (2013) available at <https://app.box.com/embed/8clil4i0dy5rlrh.swf>.

icaid so that he or she does not need to expend all of his or her assets to become eligible to receive Medicaid benefits.³⁷

Despite the benefit of the Long-Term Care Partnership Act and of knowing that a majority of one's long-term care would be paid for by long-term care insurance if one needed it, many residents still do not use long-term care insurance.³⁸ As previously discussed, educating Illinois residents about the benefits of these partnership programs before they become ineligible for long-term care insurance would likely be one way to alleviate the burden on Medicaid and individuals' families. Further, by promoting the purchase of long-term care insurance through the use of the partnership plans, residents may receive care earlier than they would if they did not have any benefits and could possibly prevent or stave off the need to receive costly institutional care.

C. Veterans' Benefits

Alternative options for payment for long-term care in Illinois exist for its approximately 740,000 veterans.³⁹ Veterans and their surviving spouses can apply for federal benefits under the United States Department of Veterans Affairs and Veterans Administration pension, and for state benefits under the Illinois Department of Veterans Affairs.⁴⁰ Illinois offers long-term nursing and health-care services to veterans that served at least one day of

37. 215 ILL. COMP. STAT. 132/15 (b)(1); <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved> ("Here's an example. Stephanie buys a PQ policy and needs care one day. Her policy pays out \$150,000 of insurance claim benefits. Stephanie earns a Medicaid asset disregard that allows her to keep an additional \$150,000 over the asset level she would otherwise have to meet in order to be eligible for Medicaid coverage. The Partnership Program also protects those assets after death from Medicaid estate recovery.").

38. *Long-Term Care: What Are the Issues?*, *supra* note 1, at 3.

39. As of September 30, 2014, the population of veterans in Illinois is 744,710. *Veteran Population*, U.S. DEP'T OF VETERANS AFFAIRS, http://www.va.gov/vetdata/Veteran_Population.asp (last updated Sept. 30, 2014) (locate and hover over Illinois to find current statistics).

40. See *Pension Benefits*, U.S. DEP'T OF VETERAN AFFAIRS, available at <http://www.benefits.va.gov/PENSION/Pensionprograminfo.pdf> (explaining eligibility requirements for pension benefits for wartime Veterans and his/her survivors).

military service during a period of war recognized by the United States Department of Veterans Affairs.⁴¹ Veterans that served during peacetime and surviving spouses may qualify if the wait list of veterans has been exhausted.⁴²

While these services provide a well-earned source of payment for veterans, they do not provide coverage or payment for the vast majority of the Illinois population.⁴³ In the interest of increased administration of long-term care, this option provides only minor assistance to the population of Illinois; however, it is important for the government to continue to educate those residents who are eligible as these benefits offer an affordable alternative to other costly options.

D. Medicare

Another payment option for small portions of long-term care for certain qualified individuals is Medicare. Medicare provides limited coverage for home care services and skilled nursing facilities for Medicare beneficiaries that are in need of skilled nursing services or therapy.⁴⁴ Medicare will fund the first twenty days of care and part of an additional eighty days of care in a skilled nursing facility following a hospital stay of three days or more.⁴⁵ Additionally, Medicare will temporarily pay for “skilled nursing, therapy, and aide services” if an individual is incapable of leaving his or her home due to a medical condition.⁴⁶ However, Medicare and many insurance plans

41. *Veteran Homes*, ILL. DEP’T OF VETERAN’S AFFAIRS, <http://www2.illinois.gov/veterans/homes/Pages/eligibility.aspx> (last visited Sept. 9, 2014).

42. *Id.*

43. The United States Census Bureau estimates that in 2013 Illinois’s population was approximately 12,882,135. *See State & County QuickFacts: Illinois*, <http://quickfacts.census.gov/qfd/states/17000.html> (last visited Oct. 27, 2014).

44. STONE, *supra* note 6, at 402; *See also* Reinhard, *supra* note 11, at 25 (“Medicare does cover limited post-acute home health care and skilled nursing facility services that follow a hospitalization – both under very specific circumstances – but these distinctions are often not clear to consumers. Medicare and other forms of health insurance cover only *health* services, not [long-term care].”).

45. STONE, *supra* note 6, at 402.

46. *Id.*

will not cover “custodial care,” which includes assistance with ADLs and personal administration of medication, such as taking eye-drops.⁴⁷

As previously discussed, many individuals approach their long-term care planning under the misconception that Medicare will cover the cost of custodial care in addition to traditional health care costs.⁴⁸ As Medicare does not cover care for long periods of time, it is not a viable option for long-term care payment for the majority of Illinois residents and should be used only as a supplementary funding source. To clarify that Medicare does not provide custodial care, Illinois should educate and train both doctors and Medicare administrators to better inform the public that they need to seek out other options to fund their long-term care needs well in advance of requiring them. Residents may waste precious time and resources believing that Medicare will cover their long-term care needs in the future, when in reality they could be saving or purchasing long-term care insurance to ensure they will be provided for when they require long-term care.

E. Medicaid

Medicaid provides the largest section of long-term care funding, and not only offers payment for services received in institutional settings but for services needed by individuals living in the community in home- and community-based care situations.⁴⁹ Thus, Medicaid fills the gap of services for

47. *Medicare and You*, CTR. FOR MEDICARE AND MEDICAID SERV., 1, 146 (2015), <http://www.medicare.gov/publications/pubs/pdf/10050.pdf> (defining custodial care as “Non-skilled personal care, like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops.” According to the Centers for Medicare and Medicaid Services, Medicare does not pay for custodial care in most cases.).

48. Health Policy Brief, *supra* note 4, at 2.

49. See Kaiser Commission on Medicaid Facts, *Medicaid and Long-Term Care Services and Supports*, THE HENRY J. KAISER FAMILY FOUND., 1 (June 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/2186-09.pdf> (“Medicaid is the nation’s major public health coverage program designed to address the acute and long-term care needs of millions of low-income Americans of all ages.”).

which Medicare and private insurance do not pay.⁵⁰ Further, Illinois expanded Medicaid under the ACA to all individuals and families below 138% of the Federal Poverty Level, which is \$16,105 for a single person in 2014.⁵¹ Medicaid was previously available to low-income individuals over sixty-five years old and disabled individuals; however, Illinois's implementation of Medicaid expansion makes all individuals under 138% of the federal poverty line eligible.⁵² As such, not only are a greater number of elderly individuals enabled to receive benefits by qualifying for Medicaid, but a greater number of individuals under the age of sixty-five are enabled to receive preventive care to maintain their health and stave off the necessity of long-term care services.

Illinois has several programs that supplement and support Medicaid payment for services that promote community-based care as a less expensive alternative to institutional care. First, Illinois's adoption of the ACA allowed expansion of Home and Community Based Services (HCBS) Waiver programs.⁵³ HCBS waiver programs enable qualified Medicaid beneficiaries to receive services in a community setting or in their homes as an alternative to receiving care in institutional settings.⁵⁴ Supportive living

50. *See id.* (stating “[m]any of these critical services are not covered by Medicare or private insurance).

51. *Illinois Medicaid Enrollment Under Affordable Care Act Exceeds Projections*, INST. FOR ILL. FISCAL SUSTAINABILITY (May 15, 2014, 10:33 AM), <http://www.civiced.org/iifs/blog/illinois-medicaid-enrollment-under-affordable-care-act-exceeds-projections>.

52. *Answers to Frequently Asked Questions: The Affordable Care Act in Illinois*, *supra* note 3.

53. Application for a §1915(c) Home and Community-Based Services Waiver, IL DEP'T OF HUMAN SERVS., 1 https://www.dhs.state.il.us/onenetlibrary/27896/documents/by_division/division%20of%20d/d/childsupportamend0314.pdf.

54. ILL. DEP'T OF HEALTHCARE AND FAMILY SERVS., *supra* note 20 (listing the nine categories of waivers: Children and Young Adults with Developmental Disabilities-Support Waiver, Children and Young Adults with Developmental Disabilities – Residential Waiver, Children that are Technology Dependent/Medically Fragile, Persons with Disabilities, Persons with Brain Injuries (BI), Adults with Developmental Disabilities, Persons who are Elderly); Section 1915(c) of the Social Security Act enables the Department of Health and Human Services to allow long-term care to be delivered in community settings through a waiver of applicable Medicaid provisions. Reinhard, et al. *supra* note 11, at 112.

facilities (SLFs) are an example of an HCBS waiver. SLFs serve both disabled individuals twenty-two years or older and individuals sixty-five years old or older that meet certain other requirements as an alternative to nursing homes.⁵⁵ These facilities aim to maintain patient autonomy and privacy in an environment that is also able to provide health and wellness services akin to a nursing home.⁵⁶ While as of July 2013, Medicaid per diem rates for SLFs dropped 2.7%, this change only made SLFs slightly more accessible to individuals.⁵⁷ These programs engender a greater focus on consumer-based community long-term care rather than institutionalized care.

One specific instance of direct promotion of community care is Illinois's adoption of Pathways to Community Living: Money Follows the Person Program (MFP)—a federal grant offered by the Centers for Medicare & Medicaid Services (CMS) that Illinois and forty-two other states have utilized to combat the great cost of long-term care.⁵⁸ Under this program, the Department of Healthcare and Family Services, Department of Human Services, Department of Aging, and Department of Housing Development Authority collaborate to promote the use of community services and assist individuals with chronic conditions and disabilities wishing to transition from institutional to community-based care.⁵⁹ This is another program that helps ease the financial burden of institutionalized long-term care by promoting

55. 89 ILL. ADMIN. CODE tit. 146 § 200(a) (eff. May 1, 2006) (listing other requirements: The Department or other State screening agency must determine the individual is “in need of nursing facility level of care and that SLF placement is appropriate to meet the needs of the individual” 89 ILL. ADMIN. CODE tit.146.220(a)(2) (eff. Aug. 1, 2009)). Additionally, the individual cannot have “a primary or secondary diagnosis of developmental disability or serious and persistent mental illness.” 89 ILL. ADMIN. CODE tit.146.220(a)(3) (eff. Aug 1, 2009); *see also* Illinois Supportive Living Program, (last visited Sept. 28, 2014), <http://www.slfillinois.com>.

56. Illinois Supportive Living Program, (last visited Sept. 28, 2014), <http://www.slfillinois.com>.

57. 89 ILL. ADMIN. CODE 153.126(g) (eff. June 27, 2013) (amended at 37 ILL. REG. 10529).

58. *Pathways to Community Living*, *supra* note 20; Reinhard, *supra* note 11, at 112.

59. *Pathways to Community Living*, *supra* note 20; *Long Term Care*, ILL. DEP'T OF HEALTHCARE AND FAMILY SERV., <http://www2.illinois.gov/hfs/MedicalCustomers/LTC/Pages/default.aspx> (last visited Sept. 28, 2014); Reinhard, *supra* note 11, at 112.

utilization of a cheaper and often more desirable community-based care. As of August 1, 2014, the Illinois MFP assisted 1,104 qualified individuals transition back into the community.⁶⁰

These programs effectively refocus the scope of long-term care on community-based as opposed to institutional care; however, their implementation still presents some issues. Primarily, residents transitioning from nursing homes to the community are frequently re-institutionalized due to the lack of infrastructure in the community to properly support their needs.⁶¹ In order to make long-term care more affordable for its residents and enable its programs to be successful, Illinois must focus on developing the community infrastructure in addition to educating residents about their options, with the goal of allowing residents in need of long-term care to stay in the community.

IV. CONCLUSION

In light of the expense of institutional care and the number of people in community care, Illinois should focus on more community-based care rather than institutional care. Of the ten million individuals in need of long-term care, 8.4 million of these individuals live in community care settings, and only 1.6 million in institutional settings.⁶² Although the expansion of Medicaid under the ACA and the various programs utilized by Illinois have attempted to change the focus of payment of long-term care away from institutional to community-based care, the rates and options available make

60. *Pathways to Community Living*, *supra* note 20.

61. *The Path to Transformation: Illinois 1115 Waiver Proposal*, <https://www.2.illinois.gov/hfs/PublicInvolvement/1115/Pages/1115.aspx> (last visited Oct. 27, 2014) (“Illinois is also currently implementing consent decrees related to three Olmstead-related class action lawsuits, by helping residents of nursing homes and other institutions to transition to the community. We have learned through the early implementation of these consent decrees, as well as implementation of the Money Follows the Person Program, that existing community infrastructure needs to be strengthened through the addition of community-based services that will enable individuals to remain in their own community post-transition and avoid re-institutionalization.”).

62. Kaiser, *supra* note 49, at 1.

even community-based long-term care unaffordable and unreachable for many residents. Illinois must focus on educating its residents on the benefits of insurance partnership programs, so they can make informed decisions as to whether to purchase costly (but beneficial) long-term care insurance and clarify that Medicare will not cover residents' custodial needs. Further, if it continues to focus on developing the infrastructure of community settings, the waiver programs will enable residents to more successfully remain in community-based settings rather than institutional settings as a way to both save money and promote independence and a sense of self-worth. The road has been paved for possible success in the long-term care for Illinois; however, much work remains to be done.

Arkansas's Section 1115 Waiver and Expansion of
Medicaid: A Path Toward Equal Care

*Morgan Carr**

“It is one of the happy incidents of the federal system, that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”¹

I. INTRODUCTION

Arkansas has established a new way to provide Medicaid to its neediest citizens. Arkansas's scheme is innovative in that it is offering subsidies for private insurance to Medicaid beneficiaries. This plan is superior to Medicaid offerings in other states because it reduces churning², improves access and quality of care, provides a better value for taxpayer dollars, and improves the risk-pool in the insurance exchange by providing a large pool of healthy adults. This article argues that other states should look to Arkansas as an example, and find innovative ways to provide better care to Medicaid beneficiaries. Part II discusses the background of the Medicaid expansion under the Affordable Care Act (ACA). Part III discusses Section 1115 waivers, the mechanism through which Arkansas established its expansion scheme. Part IV discusses the benefits of Arkansas's plan - which include a reduction in churning, improved access to care, cost effectiveness, and risk

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1. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

2. Churning occurs when patients are forced to switch back and forth between Medicaid and private insurance as their incomes fluctuate around the threshold. Typically, people lose Medicaid eligibility after their income spikes temporarily from a seasonal job or working extra hours. Jenni Bergal, *Millions Of Lower-Income People Expected to Shift Between Exchanges and Medicaid*, KAISER HEALTH NEWS (Jan. 6, 2014), <http://kaiserhealthnews.org/news/low-income-health-insurance-churn-medicaid-exchange/>.

pooling. Finally, this article concludes that further innovation is needed in America's healthcare system, and Arkansas is setting an example that other states should adopt.

II. MEDICAID EXPANSION

The ACA has given states the option to expand eligibility for Medicaid to populations that previously did not qualify for Medicaid coverage.³ Medicaid is a long-standing government program that provides health insurance coverage to certain qualified people with low-income or disabilities, and has traditionally covered only the “deserving” poor — primarily the blind, disabled, women and their children, and the impoverished elderly.⁴ The ACA expands coverage under Medicaid to all Americans earning below 133% of the federal poverty level.⁵ This newly eligible population primarily consists of childless, low-income, working-age adults.⁶ Pursuant to the ACA and the United States Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*,⁷ states are given the option to expand their Medicaid programs.⁸ Currently, twenty-five states and the District of Columbia have expanded Medicaid, eight have rejected the expansion, and the remainder are deliberating or negotiating alternative expansions with the federal government.⁹ If a state chooses to expand, the federal government will pay one hundred percent of the cost of those who

3. Carter C. Price & Christine Eibner, *For States that Opt out of Medicaid Expansion: 3.6 Million Fewer Insured and \$8.4 Billion Less in Federal Payments*, 32 HEALTH AFF. 1030, 1030-1 (2013).

4. Elizabeth Weeks Leonard, *Special Feature: Medicaid Matters: Crafting a Narrative for the Red State Option*, 102 KY. L.J. 381, 389 (2013-2014).

5. *Id.* at 388. “Single adults earning no more than \$14,856 per year—133% of the current federal poverty level—surely rank among the Nation's poor” *NFIB v. Sebelius*, 132 S. Ct. 2566, 2636 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

6. Sidney D. Watson, *Special Feature: Medicaid Matters: Medicaid, Marketplaces, and Premium Assistance: What is at Stake in Arkansas? The Perils and Pitfalls of Medicaid Expansion Through Marketplace Premium Assistance*, 102 KY. L.J. 471, 475 (2013-2014).

7. 132 S. Ct. 2566 (2012).

8. *Nat'l Fed. Of Indep't Business v. Sebelius*, 132 S. Ct. 2566, 2667 (2012).

9. Leonard, *supra* note 4, at 381.

are newly covered by the Medicaid expansion for the first three years.¹⁰ For years four through six, the federal government will pay ninety-five percent of the cost of care for the expansion population, and then will pay ninety-percent of the cost of care for the expansion population in perpetuity.¹¹ The ACA and existing Medicaid law under the Social Security Act allow for some flexibility for states as far as which benefits are provided and how care is delivered.¹² Some states, such as Arkansas, Iowa, Michigan, and Pennsylvania, have implemented the Medicaid expansion in ways that extend beyond the flexibility provided by law by obtaining approval through waivers under Section 1115 of the Social Security Act.¹³ Section 1115 waivers allow states to test innovative approaches that differ from the federal program rules.¹⁴

Congress offered generous funding to incentivize states to opt-in to Medicaid expansion.¹⁵ The costs to the states for expanding Medicaid would generally be lower than the cost of uncompensated care borne by the states after the implementation of the ACA.¹⁶ The Department of Health and Human Services (HHS) estimates that hospital uncompensated care costs in 2014 will be \$4.2 billion dollars lower than it otherwise would have been because of the twenty-five states, plus Washington D.C., expanding Medicaid at the beginning of 2014.¹⁷ Studies have shown that previous expansions of Medicaid have led to a substantial decrease in mortality, and that

10. *Id.* at 382.

11. *Id.*

12. THE KAISER FAMILY FOUND., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED: THE ACA AND RECENT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS I (2014), *available at* <http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-1115-medicare-demonstration-waivers/>.

13. *Id.*

14. *Id.*

15. Watson, *supra* note 6, at 475-76.

16. Price & Eibner, *supra* note 3, at 1034.

17. U.S. DEP'T OF HEALTH & HUMAN SERVS., ASPE ISSUE BRIEF: IMPACT OF INSURANCE EXPANSION ON HOSPITAL UNCOMPENSATED CARE COSTS IN 2014 2, *available at* http://aspe.hhs.gov/health/reports/2014/UncompensatedCare/ib_UncompensatedCare.pdf.

fully expanding Medicaid eligibility in all the states could reduce mortality by ninety thousand lives per year.¹⁸ Given the generous Congressional funding and the significant reduction in mortality created by expanding Medicaid, states should be eager to expand their Medicaid programs. If costs are of a concern, states should turn to the flexibility offered through Section 1115 Waivers to structure their programs in accordance with their budgets and their population's needs.

III. SECTION 1115 WAIVERS

The Secretary of HHS has repeatedly stated that the government will waive certain provisions of the Medicaid Act under the authority of Section 1115 of the Social Security Act to allow states to test new and innovative Medicaid programs.¹⁹ Section 1115 of the Social Security Act gives broad flexibility to the states to experiment in their programs for providing healthcare coverage to the uninsured, as long as costs to the federal government do not increase.²⁰ The federal government ensures that the budget does not increase by placing a cap on the amount of federal funds that can be spent over the life of the waiver, and the states are responsible for anything above that cap.²¹ Section 1115 waivers have been used for many years and for many purposes, such as expanding coverage, implementing managed care, and restructuring federal financing.²² Section 1115 waivers are intended for research and experimentation, so federal law requires that waivers be formally evaluated periodically.²³ The ACA creates an additional waiver, Section 1115A, which establishes the Center for Medicare

18. Price & Eibner, *supra* note 3, at 1035.

19. Watson, *supra* note 6, at 472.

20. Leonard, *supra* note 4, at 396.

21. Section 1115 waivers are generally approved for five years and then must be renewed. THE KAISER FAMILY FOUND., KAISER COMMISSION ON MEDICAID AND THE UNINSURED: FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS 1 (2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf> [hereinafter "SECTION 1115 MEDICAID"].

22. *Id.*

23. *Id.* at 2.

and Medicaid Innovation to test and evaluate different service, delivery, and payment to improve quality and slow cost growth in Medicaid.²⁴

To obtain a Section 1115 waiver, a state must submit an application to the Centers for Medicare & Medicaid Services (CMS).²⁵ Next, CMS and other HHS agencies review the waiver, and significant negotiations may occur between HHS and the state.²⁶ If the waiver is awarded, CMS issues an award letter to the state, including the terms of approval and a budget neutrality agreement.²⁷

Arkansas, with approval of the federal government, passed an alternative form of Medicaid expansion where beneficiaries are provided with premium assistance and enrolled in private plans sold through the health insurance exchanges that were established through the ACA.²⁸ Premium assistance schemes are not new - they have been available to the states to use since 1965.²⁹ However, before the ACA, no state has ever chosen to cover a large population of beneficiaries with premium assistance because of high costs and limited coverage options.³⁰ The ACA has made the establishment of large-scale premium assistance programs possible in two ways: first, if a state chooses to expand Medicaid, it receives a large amount of federal funding which will cover the high cost of premium-assistance; and second, the new health insurance marketplaces provide the infrastructure that is necessary to cover large numbers of people in non-employer based plans.³¹ The marketplaces offer a number of private insurance options called qualified health plans (QHP), which are regulated and must include a compre-

24. *Id.*

25. *Id.* at 3.

26. *Id.*

27. *Id.*

28. Leonard, *supra* note 4, at 383.

29. Maia Crawford & Shannon McMahon, *Alternative Medicaid Expansion Models: Exploring State Options*, CTR. FOR HEALTH CARE STRATEGIES, INC. 2 (2014), available at http://www.chcs.org/media/Alternative_Medicaid_Expansion_Models_Exploring_State_Options.pdf.

30. *Id.*

31. *Id.*

hensive package of services called essential health benefits.³² Arkansas is an example of how the post-ACA healthcare landscape has created opportunities for states to innovate their Medicaid programs.

IV. BENEFITS OF ARKANSAS'S PLAN

A. Reduction in Churning

All newly eligible adults in Arkansas are enrolled in premium assistance to increase provider access and reduce churning between Medicaid and private coverage due to income fluctuations.³³ Research suggests that of the ninety-six million Americans who are eligible to receive Medicaid during a given year, up to twenty-nine million of them are likely to churn between coverage options because of changes in income and circumstances.³⁴ Under a plan like Arkansas's, when Medicaid eligible individuals are enrolled in a marketplace QHP instead of traditional Medicaid, if their income rises above Medicaid eligibility levels, they can stay in their private coverage rather than switching plans and providers.³⁵ Switching between Medicaid and private plans month to month can create great difficulty for patients, as it can mean entirely different covered providers and services.³⁶ Research has shown that churning and coverage disruptions have negative effects on access to care and cause increased administrative costs.³⁷ Projections show that thirty-five percent of adults will experience a change of eligibility within six months, and fifty percent would have experienced a change within

32. *Id.*

33. Churning occurs when individuals' eligibility for Medicaid fluctuates back and forth, and they must switch between Medicaid coverage and private insurance due to income fluctuations, which are often caused by changes in hours and seasonal work. SECTION 1115 MEDICAID, *supra* note 21, at 8.

34. Crawford & McMahon, *supra* note 29.

35. *Id.*

36. Leonard, *supra* note 4, at 423.

37. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 229 (Feb. 2011).

one year.³⁸ An estimated twenty-four percent would experience two eligibility changes within one year.³⁹ In Arkansas, premium assistance is expected to reduce churning by nearly two-thirds, resulting in greater convenience and continuity of care.⁴⁰

B. Improved Access to Care

It is generally accepted knowledge that Medicaid coverage is inferior to private health insurance.⁴¹ There is an ongoing debate in the public policy community about whether having Medicaid coverage is any improvement over being uninsured.⁴² Beneficiaries enrolled in private plans will likely have better access to care than traditional Medicaid beneficiaries, because more providers accept commercial insurance than Medicaid.⁴³ A study by the Government Accountability Office in 2012 found that 7.8% of adults with Medicaid had difficulty accessing medical services, compared to 3.3% of similar adults with private insurance.⁴⁴ Additionally, a study found that in 2011, nationwide, almost one third of all physicians refused to accept new Medicaid patients, compared to nineteen percent refusing new commercial patients.⁴⁵ Medicaid is typically challenged in enlisting sufficient providers because of low rate of reimbursement.⁴⁶ Premium assistance eliminates this problem by providing beneficiaries with private insurance that is much more widely accepted by physicians.⁴⁷

38. *Id.* at 232.

39. *Id.*

40. Crawford & McMahon, *supra* note 29.

41. See generally AVIK ROY, HOW MEDICAID FAILS THE POOR (2013).

42. See Scott Gottlieb, *Medicaid is Worse Than No Coverage at All*, WALL ST. J. (March 10, 2011) available at <http://online.wsj.com/articles/SB10001424052748704758904576188280858303612>.

43. Crawford & McMahon, *supra* note 29, at 3.

44. *Id.*

45. *Id.* Sandra L. Decker, *In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help*, 31 HEALTH AFF. 1673, 1679 (2012).

46. Leonard, *supra* note 4, at 423.

47. *Id.*

C. Cost Effectiveness

CMS has imposed cost effectiveness conditions that apply to premium assistance schemes.⁴⁸ However, CMS has indicated that it will recognize considerations beyond dollar cost when evaluating a plan's cost effectiveness, including reduced churn, increased competition in marketplaces, and improved access and quality of care.⁴⁹ CMS officially waived Arkansas's cost-effectiveness requirement, and stated that Arkansas may use state developed tests of cost effectiveness to evaluate its premium assistance scheme.⁵⁰ Actuaries for the state of Arkansas estimate that private option costs will be thirteen to fourteen percent higher than public Medicaid costs.⁵¹ However, the actuaries noted that while premium assistance would likely cost thirteen to fourteen percent more than traditional Medicaid, this cost does not take into account the likely increase in Medicaid provider reimbursement rates that the state says it would need to pay to secure access to care for a Medicaid expansion population.⁵² Additionally, the State of Arkansas argued that the higher cost of purchasing private insurance on the marketplace for beneficiaries buys better access to care, thereby making the program cost-effective.⁵³

Healthcare providers, especially hospitals have been generally supportive of expansion.⁵⁴ This is because the ACA cut the amount of disproportionate share hospital (DSH) funding, which is federal funding that hospitals receive for treating a disproportionate share of uninsured or underinsured patients.⁵⁵ The ACA cut DSH funding because the expectation was, as a result of the individual mandate and Medicaid expansion, that providers

48. Crawford & McMahon, *supra* note 29, at 4.

49. *Id.*

50. *Id.* at 5.

51. *Id.*

52. *Id.*

53. *Id.* at 6.

54. Leonard, *supra* note 4, at 412.

55. *Id.*

would see fewer uninsured patients.⁵⁶ However, in states that have not expanded Medicaid, a large group of people that Congress expected to be insured are not, and providers in those states will bear the burden of reduced DSH payments and similar numbers of uninsured patients.⁵⁷

D. Risk Pooling

Increasing the number of people buying insurance on the exchanges will increase demand, which will bring more suppliers into the market, and drive down costs of insurance, which is beneficial for all citizens. Working with independent legal and actuarial consultants, the Arkansas Department of Human Services estimates that introducing 250,000 low-income adults to the marketplace will increase competition among carriers and create price pressure on providers that will result in an estimated five percent reduction in private reimbursement rates on the exchange.⁵⁸ Additionally, increasing rates of insured individuals in general in the population will improve overall health and thereby lower healthcare costs.⁵⁹ Also, it is a reasonable expectation that the Medicaid expansion population will be relatively healthy because the group largely includes the working poor, and the addition of this group to the marketplace exchange risk pools could improve the functioning of the new marketplaces.⁶⁰

V. CONCLUSION

Arkansas is at the beginning of an experimental journey. Despite the fact that premium assistance for Medicaid beneficiaries was always a possibility before the ACA, it has never been done on such a large scale. Premium assistance for private insurance for Medicaid beneficiaries levels the playing

56. *Id.*

57. *Id.*

58. *Financial Impact of Arkansas' Private Option Plan for Insurance Premium Assistance*, ARKANSAS DEP'T OF HUMAN SERVS. (2014), available at http://posting.arktimes.com/images/blogimages/2013/03/18/1363643232-dhs_private_option.pdf.

59. Leonard, *supra* note 4, at 414.

60. Leonard, *supra* note 4, at 422.

field and provides our society's neediest with an acceptable level of care. Private insurance for Medicaid beneficiaries will greatly reduce patients churning between Medicaid and private coverage, will improve access to and quality of care for beneficiaries, will provide a better value for taxpayer dollars, and will pool the risk in the exchanges by adding a large population of healthy adults. There is no doubt that innovation is needed in America's healthcare system, particularly in Medicaid, and Arkansas is setting forth a new standard that other states should look to as an example.

A Storied Past Demands Greater Access to Health
Care Now and Into the Future

*Sumaya Noush**

I. INTRODUCTION

The future health of the United States will largely be determined by how effectively the federal government eliminates health disparities that disproportionately burden vulnerable populations, including the American Indians and Alaska Natives (AI/AN).¹ There has been a longstanding campaign to educate many new generations to see this population's access to health care in its fullest expression: as a right to basic human capabilities. With the success of the Patient Protection and Affordable Care Act (ACA), it appears as if now, more than ever before, financial help for health coverage may be able to reach this widely displaced and underfunded population.² Although the ACA was designed to adequately meet the basic needs of most individuals in the aggregate, it is inadequate in meeting the basic needs of those most vulnerable, especially AI/AN. This shortfall represents the everlasting tensions and complex relationship between the United States government and AI/AN, as well as trends of AI/AN disenfranchisement.³

This article will examine the time-honored issues surrounding AI/AN's

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1. *Minority Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/minorityhealth/populations.html> (last updated Feb. 5, 2014).

2. Patient Protection and Affordable Care Act, Subtitle III- Protections for American Indians and Alaska Natives, Special Rules Relative to Indians, Pub. L. No. 111-148, 42 U.S.C. § 2901 (2010), available at <http://www.mcms.org/sites/default/files/ppaca consolidated.pdf>.

3. Nat'l Educ. Ass'n, *Focus on Tomorrow: What Matters Most in 2008 and Beyond*, 3 (2008-2009), available at <http://www.nea.org/assets/docs/HE/votingfocus08.pdf>.

access to health care and will demonstrate why, under a traditional as well as sufficiency of capabilities approach to distributive justice, the U.S. government has a heightened duty to provide sufficient funding to programs designed to reach these populations and eliminate foreseeable deterrents to AI/AN enrollment in ACA-expanded Medicaid as a means of elevating their health to a just threshold level.⁴ Part II of this article will examine the unique relationship between the U.S. government and AI/AN, concentrating particularly on AI/AN's unique health care needs. Part III will address how the ACA affects AI/AN and the roles of the states in expanding their health coverage. Finally, Part IV will address why justice demands increased access to health care for AI/AN. Although much of what will be described regarding AI/AN health disparities and the law is straightforward, other parts of this article may involve more contemplation as they are set forth with a very broad and visionary view of how improved health care access stems from an awareness of past harms experienced by these populations.

II. THE FEDERAL TRUST RESPONSIBILITY: A FEDERAL-TRIBAL RELATIONSHIP WARRANTING INCREASED FUNDING TO ADDRESS LOOMING HEALTH CONCERNS

The contours of the relationship between the federal government and tribal governments are shaped by hundreds of years of legal precedent.⁵ The status of federally recognized tribes as sovereign entities with a unique gov-

4. Both of these models attempt to outline characteristics of a socially just distribution of goods in society. American Philosopher John Rawls of Harvard University arguably pioneered traditional distributive justice in his book, *A Theory of Justice*, where he argues that justice has two principles but that fairness is the end result. JOHN RAWLS, *THEORY OF JUSTICE*, 3 (2nd ed. 1999). Martha Nussbaum of the University of Chicago and Amartya Sen of Harvard University have promoted a capabilities approach to distributive justice. Nussbaum has famously problematized the very language used to identify human, social, or familial rights and instead focuses on the language of capabilities and human functioning. Martha C. Nussbaum, *Capabilities and Human Rights*, 66 *Fordham L. Rev.* 273 (1997). Sen has highlighted the connection between human rights and capabilities in the global realm. Amartya Sen, *Human Rights and Capabilities*, 6 *J. Hum. Dev.* 151 (2005).

5. Snyder Act of 1921, 25 U.S.C.A. § 13 (West 2014). The Indian Self-Determination and Education Assistance Act of 1975, 25 U.S.C. §§450(a)-450n (2006). *Worcester v. Georgia*, 31 U.S. 515 (1832). *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831) (“[AI/ANs’] relation to the United States resembles that of a ward to his guardian.”).

ernment-to-government relationship with the United States holds important weight in the balance of intergovernmental relations.⁶ It is weighed against the accompanying fact that AI/AN are beneficiaries of certain federal programs due to the special debt the United States owes this population for their 400 million acres of land secession.⁷ Although challenging, striking equilibrium between self-governance and special beneficiary must be seriously considered when creating and funding for a culturally competent and satisfactory health care program.

A. *Brief History of the Socio-Political Arrangement Creating a Right to Health*

The relationship between the sovereign tribes and the federal government greatly hinges on the latter's fulfillment of its federal trust responsibility. The federal trust responsibility is the United States' fiduciary obligation to protect tribal treaty rights, lands, assets, and resources as well as to carry out the mandates of federal law that relate to AI/AN.⁸ The discussion below briefly chronicles how the federal trust responsibility has been executed, how its shortcomings have been remedied with follow-up legislation, and how one general theme prevails throughout: federal underfunding.

There are currently 562 federally recognized tribes spread across thirty-five states.⁹ The federal government has provided American Indians (AI) health care based on their membership in one of these tribes.¹⁰ Generally noting that, "an American Indian person is someone who has blood degree from and is recognized as such by a federally recognized tribe or village

6. Alex Dyste, *It's Hard Out Here for an American Indian: Implications of the Patient Protection and Affordable Care Act for the American Indian Population*, 32 LAW & INEQ. 95, 96 (2014).

7. *Id.*

8. U.S. DEP'T. OF THE INTERIOR, *Indian Affairs, Frequently Asked Questions*, <http://www.bia.gov/FAQs/> (last updated Dec. 23, 2014).

9. Nw. Portland Area Indian Health Bd., *A National Roundtable on the Indian Health System and Medicaid Reform*, URBAN INST. 2 (2005), available at http://www.urban.org/uploadedpdf/411236_indian_health_system.pdf.

10. *See id.*

and or the United States.”¹¹ As of January 2012, the total population of AI/AN, including those of more than one-race, was 5.2 million or 1.7% of the total U.S. population.¹²

In 1921, the federal government enacted the Snyder Act to fulfill its federal trust responsibility and provide AI with health care.¹³ Many consider this legislation to have been the leading AI/AN welfare law of the early twentieth century because it authorized federal appropriations for this population’s health services.¹⁴ Although the Snyder Act categorized the responsibility to administer health services as under Congress’ purview, it only required Congress to do this “from time to time,” whenever they considered it proper for the benefit, care, and assistance of this population.¹⁵ Soon after, Congress passed the Indian Citizenship Act of 1924 to expand AI’s citizenship status to full U.S. citizens and, by extension, their eligibility for bene-

11. *American Indian People and Tribes*, INDIAN HEALTH SERV. 6, available at http://www.ihs.gov/bemidji/documents/resources/minnesota/Am_Indian_People_Tribes.doc (last visited Oct.14, 2014). *Blood Quantum Influences Native American Identity*, NATIVE VILLAGE, available at <http://www.nativevillage.org/Messages%20from%20the%20People/Blood%20Quantums%20for%20Native%20Americans.htm> (“The term was first used in the 1700s by Colonial Virginia. Those who were more than 50% Native American had their rights restricted. Today, the federal government uses [the term] to determine the benefit a tribe receives based on its population.” However, blood quantum requirements differ depending on an individual tribe’s requirements for membership, making membership in some tribes harder than others. For instance, to be a member of the Apache Tribe of Oklahoma requires 1/8 degree blood quantum, whereas membership in the White Mountain Apache Tribe of Arizona requires ½ degree blood quantum.)

12. U.S. CENSUS BUREAU, THE 2010 AMERICAN INDIAN AND ALASKA NATIVE POPULATION BRIEF, available at <http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf> (This census became available January 2012).

13. Koral E. Fusselman, *Native American Health Care: Is The Indian Health Care Reauthorization and Improvement Act of 2009 Enough to Address Persistent Health Problems Within the Native American Community?*, 18 WASH. & LEE K. CIV. RTS. & SOC. JUST. 389, 395 (2012) (“The Snyder Act provided a limited number of programs and authorized the BIA [Bureau of Indian Affairs] to ‘direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians,’ for, among other things, the ‘relief of distress and conservation of health.’”). U.S. DEP’T OF STATE, OFFICE OF THE HISTORIAN, *Milestones*, available at <https://history.state.gov/milestones/1866-1898/alaska-purchase> (The Snyder Act of 1921 predated Alaska becoming a state in 1959, so this section is generally about Congress’ right to administer health care to the AI population.)

14. See *Nw. Portland Area Indian Health Bd.*, *supra* note 9, at 14.

15. *Dyste*, *supra* note 6, at 103.

fits that are only available to full citizens.¹⁶ The Snyder Act was insufficient at fulfilling this federal trust obligation to AI, so in the 1950s, the responsibility over health services for AI transferred over to the Department of Health and Human Services (HHS).¹⁷

In 1955, the government created the Indian Health Service (IHS) as a federal agency within the HHS responsible for delivering health services to AI in accord with the federal trust responsibility by raising “the health status of [AI] to the highest level.”¹⁸ Currently the IHS is organized into twelve federally designated geographic service areas and operates a system of health facilities.¹⁹ In 1975, the Indian Self-Determination and Education Assistance Act (ISDEAA) was created to uphold the federal trust responsibility, establish tribal involvement in the administration of federal agencies, and reaffirm AI/AN’s need for health care.²⁰ The ISDEAA gave tribes the option of staffing the IHS programs within their communities under self-governance compacts.²¹ These compacts instilled greater administrative power in the tribes over the development of the IHS even though the federal

16. *Id.*

17. INDIAN HEALTH SERV., *The First 50 Years of the Indian Health Service: Caring and Curing*, 3 (2005), available at http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/GOLD_BOOK_part1.pdf (“The health status of Indians remained poor during the following three decades. Several studies of Indian health, including those by the Institute for Government Research (1928), the Hoover Commission (1948), and the American Medical Association found high infant mortality and excessive deaths from infectious disease. Based on these studies, efforts were made to transfer the Indian health program from the BIA to the United States Public Health Services (USPHS) in the Department of Health, Education, and Welfare. [. . .] On July 1, 1955, about 2,500 health program personnel of the BIA, along with 48 hospitals, 18 health centers, 62 stations, 13 school infirmaries, and other locations, came under the jurisdiction of the newly created Indian Health Service.”). See Fusselman, *supra* note 13, at 395.

18. INDIAN HEALTH SERV., *supra* note 17. Nw. Portland Area Indian Health Bd., *supra* note 9, at 12. INDIAN HEALTH SERV., <http://www.ihs.gov/aboutihs/> (last visited Sept. 26, 2014).

19. U.S. GOV’T. ACCOUNTING OFFICE, GAO-13-553, MOST AMERICAN INDIANS AND ALASKA NATIVES POTENTIALLY ELIGIBLE FOR EXPANDED HEALTH COVERAGE, BUT ACTION NEEDED TO INCREASE ENROLLMENT 3 (Sept. 2013), available at <http://www.gao.gov/assets/660/657394.pdf>.

20. Fusselman, *supra* note 13, at 396 (Although the federal government is in charge of the IHS, the tribes are involved in the staffing and administration of the IHS’ programs.).

21. Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures and Practices*, 21 AM. INDIAN L. REV. 211, 223 (1997).

government is the authorizer of this program.²² Funding for the ISDEAA, however, failed to grow in unison along with the number of AI/AN serviced by the IHS.²³ In response to this dwindling funding, Congress enacted the Indian Health Care Improvement Act of 1976 (IHCIA) to authorize programs aimed at achieving the policy goal of elevating AI/AN's health status to its highest possible level.²⁴ The IHCIA sparked more research into AI/AN's health needs and Congress increased funding as a way to incentivize health care practitioners to treat this population of patients.²⁵

In 1988 and 1992, Congress enacted several amendments to the IHCIA to address AI/AN's health concerns, particularly diabetes, alcoholism and Fetal Alcohol Syndrome.²⁶ The 1992 IHCIA amendments included health goals for the Alaska Native (AN) population as well as appropriations for healthcare projects through 2000.²⁷ "Since 2000, however, Congress has continued to appropriate funds only on an annual basis. [With the successful passing of the ACA in 2010, Congress finally amended this arrange-

22. *Id.*

23. Fusselman, *supra* note 13, at 396 ("[The ISDEAA authorized] tribal involvement in the administration of federal agencies, including the IHS, and reaffirming the need for comprehensive health care for Native Americans. The ISDEAA helped to increase the number of Native Americans serviced by the IHS, but funding was arbitrary and failed to address the increased usage of federal programs by Native Americans.").

24. *Id.* ("[. . .] The IHCIA 1976 was comprehensive, authorizing numerous programs aimed at 'providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to affect that policy.' The Act found that the health needs of Native Americans were severe and the health status of Native Americans was far below that of the general population. The potential for shrinking this health gap was threatened by several issues including inadequate and outdated facilities, personnel shortages, the inability of many Native Americans to access 'health services due to remote residences,' and inadequate and dangerous transportation systems.").

25. *Id.* at 397.

26. *Id.* at 398-99. *Indian Health Care Improvement Act Permanent; Supreme Court Decision Upholds Reauthorization*, NAT'L CONGRESS OF AM. INDIANS, available at <http://www.ncai.org/news/articles/2012/06/28/indian-health-care-improvement-act-permanent-supreme-court-decision-upholds-reauthorization> ("This is an important step for health care in Indian Country; the permanence of the Indian Health Care Improvement Act has been affirmed and NCAI [The National Congress of American Indians] will stay focused on working with all members of Congress to uphold the trust responsibility to tribes," said Jefferson Keep, President of NCAI, the nation's oldest and most representative American Indian and Alaska Native advocacy organization.").

27. Fusselman, *supra* note 13, at 400.

ment.]”²⁸ The ACA includes a permanent reauthorization of the IHCA, but does not provide appropriations to continue the IHCA’s programs, including the IHS.²⁹ However, the permanent reauthorization could mean future funding that will be given to the IHCA to authorize programs that are better equipped to meet the mission of elevating the health status of AI/AN.³⁰ Although the reauthorization in the ACA represents a step in the right direction for meeting the federal trust responsibility, there are still several weaknesses that merit consideration for finally improving AI/AN’s access to health care.

B. *Historical Health Disparities Plaguing the AI/AN Population*

With the advent of the IHS in 1955 came the opportunity to track the health issues particular to the AI/AN population.³¹ Even the earliest collected information remains useful as a baseline from which to measure any health change or disparities over the last nearly seventy years.³² The research from the 1950s indicated that AI had a higher mortality rate compared to the general population and were more likely to die from communicable diseases.³³ Data such as this, combined with newly collected information, illustrates not only that the health disparities between AI/AN and the rest of the United States have deep roots, but also that these disparities have persisted over time.

The current research suggests that there are several physical health issues that are especially prevalent in the AI/AN demographic that have generally

28. *Id.* at 400.

29. *Id.* at 407. Dyste, *supra* note 6, at 107.

30. NAT’L CONGRESS OF AM. INDIANS, *supra* note 26 (“The passage of the IHCA on March 23, 2010 represented a fourteen year-long effort by NCAI, tribal leaders, and advocates to make permanent the legislative commitment by the federal government to deliver health care for [AI/AN].”).

31. U.S. GOV’T ACCOUNTING OFFICE, *supra* note 19, at 4.

32. Stephen J. Kunitz et al., *Historical Trends and Regional Differences in All-Cause and Amenable Mortality Among American Indians and Alaska Natives Since 1950*, 104 AM. J. PUB. HEALTH 268 (2014).

33. *Id.* at 268.

not subsided over time relative to other demographic groups.³⁴ For instance, AI have historically battled with diabetes rendering this population 420% more likely than the general population to die from diabetes.³⁵ Also, AI youth suffer from diabetes at alarming rates, far above the rate of children in other demographic groups.³⁶ Additionally, AI are estimated to be 650% more likely to die from tuberculosis, 280% more likely to die from accidents, and 52% more likely to die from pneumonia or influenza.³⁷ This population's limited access to appropriate health facilities, poor access to health insurance, insufficient federal funding, quality of care issues, disproportionate poverty and poor education, are key factors contributing to these health disparities.³⁸ Furthermore, these health issues largely cannot be divorced from the behavioral and mental health problems that are also identified to be very prevalent in the AI/AN demographic.³⁹

Behavioral and mental health problems such as substance and alcohol abuse, suicide, and domestic violence are especially burdensome on the tribes both emotionally and economically.⁴⁰ Consequently, depression, anxiety, violence, and suicide are regularly reported among all age groups.⁴¹ AI are reportedly 770% more likely to die from alcoholism than the general population.⁴² Also, the very geographic isolation of the AN villages from the remainder of the state has resulted in limited access to an already scarce

34. Dyste, *supra* note 6, at 101 (The author of this article realizes that categorizing the rest of America as non-American Indian, white or non-white dismisses the many nuances in race, ethnicity and identity that are so important in sociological studies such as this one. Therefore, in attempt to not trivialize the significance of these often blurred racial categories, the author has chosen to use the terms, "other demographic groups," and "general population," to signal the counterpart categories that are compared to AI/AN throughout this subsection.).

35. *Id.*

36. Fusselman, *supra* note 13, at 403.

37. Dyste, *supra* note 6, at 101.

38. *Id.*

39. *Id.*

40. *Id.*

41. Fusselman, *supra* note 13, at 405.

42. Dyste, *supra* note 6, at 101.

number of mental health professionals.⁴³ A rampant issue exists particularly with youth suicide and violent death in these areas.⁴⁴ That said, most AI do not actually live rurally as 66% of the population lives in urban areas, but these too are underserved by the IHS due to federal underfunding.⁴⁵

While AI/AN are in dire need of healthcare providers, the IHS has a very difficult time fulfilling this need on tribal sites.⁴⁶ Even when physicians are brought onto the sites, the IHS struggles with a very low retention rate.⁴⁷ In fact, the average employment period is 8.1 years, forcing the IHS to hire nearly 1,200 new practitioners annually to fill the 900 vacancies that arise every year.⁴⁸ The IHS is responsible for eliminating these health disparities, but chronic underfunding has made doing so a persistent challenge.⁴⁹ Compounding the difficulty of provider-vacancy are community leaders who seek to ensure that when care is provided, it will be highly culturally competent.⁵⁰ This adds an increased challenge as providers are requested to provide both traditional holistic and western medicines.⁵¹

III. THE ACA AND THE ROLE THE STATES HAVE IN ADDRESSING THE ACCESS ISSUES

The ACA is a complicated piece of legislation generally intended to address how health care is unique in being a market that most individuals participate in eventually, even if unintentionally, and that requires shared fund-

43. Nw. Portland Area Indian Health Bd., *supra* note 9, at 7.

44. *Id.*

45. Caryn Trombino, *Changing the Borders of the Federal Trust Obligation: The Urban Indian Health Care Crisis*, 8 LEGIS. & PUB. POLICY 129, 146 (2004).

46. Fusselman, *supra* note 13, at 400.

47. *Id.* at 401 (“The unique circumstances of Native American health care sites are a primary cause of the extremely high vacancy rates reported. Distant and rural locations combined with inadequate facilities, lack of pay parity, inadequate housing, and insufficient local opportunities for spouses and children have discouraged many eligible and well-qualified candidates from accepting positions with the IHS.”).

48. *Id.*

49. Dyste, *supra* note 6, at 101.

50. Nw. Portland Area Indian Health Bd., *supra* note 9, at 10.

51. *Id.*

ing in order to be sustainable.⁵² The ACA entrusts individual states with the responsibility to provide Medicaid to adults with incomes up to 138% of the federal poverty level (FPL), including AI/AN.⁵³ The ACA also specifically has qualifications that address the AI/AN population, including the elimination of cost sharing for services provided to certain enrollees at or below 300% of the FPL or for services provided by the IHS regardless of the enrollee's income.⁵⁴ Further, the ACA exempts AI/AN from being subject to a federal tax if they do not obtain health insurance from the federal government.⁵⁵ This exemption extends also to AI/AN who are not enrolled in a federally recognized tribe but who are eligible for services from the IHS.⁵⁶ Although obvious issues within this current framework include the failure to extend cost sharing and thus accountability over one's health to all AI/AN, the goal for the remainder of this section is to address how the risks in failing to expand Medicaid in states where there is a high AI population are outweighed by the benefits of expansion.

A. *States Have Too Much Ability to Diminish the Federal Trust Relationship*

Whether individual states expand Medicaid will determine AI/AN's Medicaid eligibility and whether some of the financial burden put on the IHS will be alleviated.⁵⁷ "Excluding those already enrolled, potential new enrollment in Medicaid could exceed [27%] for those identifying as AI/AN alone, and almost [25%] for those identifying as AI/AN alone or in combination with another race."⁵⁸ Of those AI/AN who are identified with a federal tribe, about 16% will be newly eligible under the ACA and about 11%

52. See Nat'l Fed. of Indep. Bus. v. Kathleen Sebelius, 132 S. Ct. 2566 (2012).

53. U.S. GOV'T ACCOUNTING OFFICE, *supra* note 19, at 4.

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.* at 7.

58. *Id.* at 6.

are currently eligible but not enrolled.⁵⁹ This latter statistic is especially indicative of why the states need to adopt strategies to increase the enrollment and fulfill the federal government's trust responsibility. Of the twelve existing IHS service areas, there are some located in states that may not expand their Medicaid programs in the near future.⁶⁰ Of particular concern is Oklahoma because this state has historically catered to the largest AI population but has yet to expand its Medicaid program.⁶¹ The issues with Oklahoma's choice to not expand its Medicaid program can be extrapolated to address all other states that have AI populations but are choosing not to expand.

Since 2012, Oklahoma opted out of expanding its Medicaid program.⁶² Oklahoma Governor Mary Fallin decided not to participate in the expansion because it would be unaffordable.⁶³ The current Oklahoma program under Governor Fallin's wing called "Insure Oklahoma," is designed to cover adults earning up to 200% of the FPL but it does not have all of the features that the Centers for Medicare and Medicaid Services (CMS) require to keep the state program running and it is scheduled to be shut down in one year.⁶⁴ Therefore, Oklahoma may need to expand its Medicaid program in order to keep those beneficiaries they currently provide coverage for protected regardless of the state's budget concerns. The 2014 potential new enrollment

59. *Id.*

60. See *Status of State Action on the Medicaid Expansion Decisions*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (last updated Dec. 17, 2014). See Kimberly Leonard, *Americans Vote Against Greater Medicaid Reach*, U.S. NEWS & WORLD REPORT (Nov. 5, 2014), <http://www.usnews.com/news/articles/2014/11/05/us-voters-say-no-to-obamacare-medicaid-expansion>.

61. U.S. GOV'T ACCOUNTING OFFICE, *supra* note 19, at 7.

62. Ctrs. For Medicare & Medicaid Servs., *Oklahoma Medicaid Moving Forward in 2014*, MEDICAID.GOV (2014), <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/oklahoma.html>.

63. Jeffrey Young, *Mary Fallin, Oklahoma Governor, Rejects Medicaid Expansion, Health Insurance Exchanges* (Sept. 28, 2014), http://www.huffingtonpost.com/2012/11/19/mary-fallin-oklahoma-health-care_n_2159737.html. Jason Millman, *Oklahoma is winning its Medicaid standoff with the feds- for now*, (July 2, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/07/01/oklahoma-is-winning-its-medicaid-standoff-with-the-feds-for-now/>.

64. Millman, *supra* note 63.

in Oklahoma's Medicaid program would have surpassed an estimated 76,000 for individuals who identify solely as AI/AN and over 137,000 for those identifying as AI/AN alone or in combination with another race.⁶⁵ The health issues plaguing AI/AN combined with incredible federal underfunding for the IHS necessitate an increased amount of effort to secure health coverage for these individuals. Proper Medicaid coverage will allow AI/AN's health care needs to be addressed while properly reimbursing their service providers at IHS. Also, the ongoing lack of funding hinders IHS's ability to conduct proper outreach initiatives to at least increase the Medicaid membership to those currently eligible individuals, even without the expansion.⁶⁶

Oklahoma's decision not to expand Medicaid interrupts the federal government's federal trust responsibility to care for AI/AN's health. The federal government has promised to pay the full expansion coverage costs for each state until 2016 and then reduce their assistance only 10% in 2022 and beyond.⁶⁷ The financial burden that this puts on the state is outweighed by the drastic health care needs that the largely underfunded IHS service area requires. Furthermore, any financial burden is secondary to the federal trust promise to AI that predates as well as preempts the state-centric views of legislative autonomy.⁶⁸

IV. DISTRIBUTIVE JUSTICE: MORALLY JUSTIFIED INEQUALITY TO MEET THE MOST NEED

AI/AN depend on the federal government for their access to health care but they are also residents of the states in which they live.⁶⁹ This incredibly ambiguous political identity combined with the past secession of several hundred million acres of land warrants an unequally higher distribution of

65. U.S. GOV'T ACCOUNTING OFFICE, *supra* note 19, at 7.

66. *Id.* at 6.

67. Young, *supra* note 63.

68. Dyste, *supra* note 6, at 116.

69. *Id.* See also INDIAN HEALTH SERV., *supra* note 11, at 7.

healthcare funding to these populations.⁷⁰ Although it may have been considered a benefit to excuse AI/AN from the ACA mandate, in all actuality, this is not likely the case given the low AI/AN enrollment in Medicaid.⁷¹ Given the ACA-related AI/AN provisions are subject to the states' opting-in to expand their Medicaid programs, Congress did not do enough by only reauthorizing the ICHIA in the ACA because they did not also provide the increased funding necessary to overcome any state Medicaid expansion hurdles.⁷²

The ACA Medicaid expansion could be especially beneficial to AI/AN because of the qualification statistics mentioned earlier.⁷³ However, the Medicaid expansion overlooks the fact that many AI/AN hesitate to enroll in public programs.⁷⁴ Some AI/AN may not enroll because they generally hold the federal government accountable for making sure that their health care needs are met.⁷⁵ "This perspective stems from [AI]'s view that they purchased health care at the lofty cost of 400 million acres of land, and the cumbersome Medicare and Medicaid registration and enrollment processes are not a burden they bargained for."⁷⁶ Relatedly, other past infringements on AI/AN land and peoples has understandably created a great distrust in the government and the thought of government control over AI/AN health is worrisome for many members of this population.⁷⁷ There is also a pre-

70. Dyste, *supra* note 6, at 114 (referencing the 400 million acres of land that this population has ceded in the past).

71. *See id.*

72. *Id.* at 117.

73. U.S. GOV'T ACCOUNTING OFFICE, *supra* note 19, at 6. Dyste, *supra* note 6, at 101 ("At the end of the day, the benefits that the ACA can realize are too tremendous to risk.").

74. Dyste, *supra* note 6, at 113 ("Native Americans, historically do not enroll in public programs such as Medicare and Medicaid.").

75. *Id.*

76. *Id.*

77. *Id.*; Andrew Boxer, *Native Americans and the Federal Government*, HIST. REV. (Sept. 2009), available at <http://www.historytoday.com/andrew-boxer/native-americans-and-federal-government> (The following are just three examples of past harms to AI/AN by the federal government. During the late 19th century, the U.S. government policy was to assimilate AIs into mainstream American society as a way to introduce them into "civilized life," even if that meant without the consent of AIs. During WWII, the tribal reservations lost fur-

vailing stigma in program enrollment as it may signal that the individual is lazy or needy.⁷⁸ Additionally, several incidents have occurred where social workers or other staff have mistreated these populations to the point where they feel this is a barrier to their health care access.⁷⁹

\$5.5 billion was designated for IHS improvements within the ACA budget.⁸⁰ Funding should not be capped at this amount if it ends up being inadequate for elevating the health and wellbeing of AI/AN. In light of innumerable past harms to AI/AN, this population's justifiable distrust with government-sponsored programs, and the reasonable foreseeability that some states would not opt to expand their Medicaid programs all suggests that the federal government has a heightened responsibility to provide more funding to the IHS.⁸¹ Arguments of distributive justice, both traditional and otherwise, can best demonstrate why the federal government has a heightened obligation to the AI/AN population to finally meet their health care needs.⁸²

A. *Rawls: A Social Contract Based on the Difference Principle*

John Rawls' idea of a reflective equilibrium and distributive justice is the basis for the argument that the federal government has a heightened duty to AI/AN to meet their health care needs. In particular, the portion of Rawls' theory known as the "difference principle," suggests that when there are finite resources, such as healthcare funding, there is a greater need to distribute these resources in a just and equitable way.⁸³ Rawls argues that if we were to think of constructing the most optimal social arrangement or institu-

ther land to be used for gunnery ranges and some for the housing of Japanese-American internees. Finally, there was the post-WWII policy of relocating these populations to the cities where job opportunities were better.).

78. Dyste, *supra* note 6, at 114.

79. *Id.*

80. *Id.* at 111.

81. *Id.* at 117.

82. See *supra* note 4 (explaining the differences between the two justice lenses that will be used to make this argument).

83. RAWLS, *supra* note 4, at 13.

tion from behind a veil of ignorance, a space of economic, social and political neutrality, it would be in everyone's best interest to permit only those inequalities that work to the advantage of the least well off members.⁸⁴ In fact, Rawls holds that it is only from behind this veil that we can see the importance of distributing limited resources in a way that minimizes the potential harms and maximizes the prospects of individuals who are the worst off.⁸⁵ When put to practice, those who are least well off deserve any inequalities in the distribution of benefits or goods that will elevate their status.⁸⁶

AI/AN are a particularly disenfranchised population given their comorbid health issues as well as their turbulent history of colonialism, and consequently require greater access to health care.⁸⁷ While the ACA indefinitely extends the IHCA, Congress should have also provided the necessary appropriations for improving the success of the programs the ICHIA authorizes in the event that some of the states did not to expand their Medicaid programs. In order to account for the total amount of funding needed, the \$5.5 billion designated for IHS improvements should only be a starting point rather than a cap. The reasonable foreseeability of some states opting not to expand their Medicaid programs combined with this lack of necessary increased funding has led to severely unequal access to health care for AI/ANs. The IHS' mission, which rests on the federal trust responsibility, is to elevate the health of the AI/AN population.⁸⁸ Under a Rawlsian theory of

84. *Id.* ("Since each desires to protect his interests, his capacity to advance his conception of the good, no one has a reason to acquiesce in an enduring loss for himself in order to bring about a greater net balance of satisfaction."). See MICHAEL J. SANDEL, *JUSTICE* 141 (2009).

85. RAWLS, *supra* note 4, at 13 ("I shall maintain instead that persons in the initial situation would choose two rather different principles: the first requires equality in the assignment of basic rights and duties, while the second holds that social and economic inequalities, for example inequalities of wealth and authority, are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society.")

86. *Id.*

87. See Dyste, *supra* note 6, at 100.

88. INDIAN HEALTH SERV., *supra* note 11.

distributive justice, until and unless the goal of elevating the health of the AI/AN population is met, a disproportionately high amount of federal funding for the IHCA is recommended.

B. Ram-Tiktin's Functional Capabilities to Health Care as Right

The federal trust responsibility is accepted as the promise of health care to the AI/AN population.⁸⁹ As discussed above, Rawls' account of justice warrants a disproportionate amount of federal funding to the IHS to address AI/AN health care needs and correct the disparities.⁹⁰ Next, Martha Nussbaum's capabilities theory of justice asks and answers questions such as "what is the quality of life?" and "what is the relevant type of equality that we should consider in political planning?"⁹¹ Nussbaum lists "a good enough human life" as a capability central for achieving a flourishing life.⁹² Below this threshold, Efrat Ram-Tiktin's claims of injustice can apply.⁹³ Ram-Tiktin's concern is in bridging the qualitative differences to health care access amongst people.⁹⁴

"If people have the basic capabilities needed to live a good life, the quantitative differences among them are not a concern of justice. Therefore, state health institutions are not obligated to equalize peoples' states of health [. . .] but to guarantee them sufficiency of capabilities that will enable them to implement their life plans and exercise positive freedom. In this view, only those beneath the basic human functional capabilities threshold level or in jeopardy of falling beneath [. . .] have a claim-right

89. Dyste, *supra* note 6, at 118.

90. RAWLS, *supra* note 4, at 13.

91. See Nussbaum, *supra* note 4, at 279 (The author of this article acknowledges that there is so much more to be said about Nussbaum's long and broad lists of rights and capabilities, but for the purposes of this article, the author seeks to tailor the conversation to a very modern take on Nussbaum's theory and how it would address this article's concerns about health care access.).

92. Efrat Ram-Tiktin, *The Right to Health Care as a Right to Basic Human Functional Capabilities*, 15 ETHICAL THEORY & MORAL PRAC. 337, 339 (2012).

93. *Id.*

94. *Id.* at 340 ("According to my account, our moral concern is toward qualitative rather than quantitative differences among people. The fact that person A has better capabilities than B [. . .] is not morally troubling as long as person B has the basic ability to walk.").

to health care.”⁹⁵

Ram-Tiktin acknowledges nine biological factors of human functional capabilities including thinking, emotions, and metabolism, but this is not particularly important for the purposes of this article.⁹⁶ What is important, however, is Ram-Tiktin’s claim that government has a duty to assure that every individual has the entire range of capabilities needed to exercise positive freedom to the furthest extent possible.⁹⁷ Any individual lacking in these capabilities is below the threshold, and individuals farther beneath the sufficiency-threshold have a stronger claim to justice by the state than those just beneath the threshold.⁹⁸ A key to the goal of elevating those below the sufficiency threshold is to maximize the net benefit, not necessarily the number of beneficiaries.⁹⁹ This means that where the greatest *need* is, not the greatest number, ought to dictate how to best allocate finite healthcare resources.¹⁰⁰

This theory generally applies to the AI/AN populations in a couple of ways. AI/AN do not comprise more than 1.7% of the total U.S. population.¹⁰¹ Therefore, the number of individuals to benefit from a disproportionate allocation of funding under a Rawlsian theory of justice is not going to be great, even though we can consider this population to be amongst the worst off in terms of health. Therefore, given the overwhelming number of health issues that are plaguing AI/AN, it is the net benefit of their increased

95. *Id.*

96. *Id.* at 341 (“In identifying the basic human functional capabilities, I explored human physiology and identified nine key systems of physiological and psychological capabilities necessary for individuals to lead good lives: thinking and emotions, senses, circulation, respiration, digestion and metabolism, movement and balance, immunity and excretion, fertility, and hormonal control. Each system of capabilities is important in itself, and a higher capability in one system does not invalidate someone’s claim for compensation if there is some functional deficiency in another system.”).

97. *Id.*

98. *See id.* at 342-343.

99. *Id.* at 343.

100. *See id.* at 349.

101. INDIAN HEALTH SERV., *supra* note 11.

access to health care that will greatly improve their capabilities of achieving human flourishing. Under this double-tiered distributive justice model, the U.S. government has a moral obligation to fund for the health care of the AI/AN population because of the severity of AI/AN's health care needs in addition to AI/AN centralization in states where there is a high demand for health care, but no Medicaid expansion.¹⁰²

V. CONCLUSION

Questions about Congress' legislative commitment to fulfilling the federal government's promise to AI/AN have given way to more specific questions about how Congress can actually guarantee the funding for improving AI/AN's access to health care. The federal government has a fiduciary obligation towards meeting AI/AN's health care needs. This fiduciary obligation is best understood as a heightened duty to elevate AI/AN's access to health care given past harms, the number of benefits to be gained, and the overall distrust that needs to be remedied for there to be a prosperous future relationship.¹⁰³ Given the underutilization of Medicaid by AI/AN, the federal government can finally meet its federal trust obligation through the ACA's permanent reauthorization of the IHCA by increasing its program funding. One suggestion for how the government can do this is to redistribute the funding they would have given states that have chosen to not expand their Medicaid programs to go towards the IHS. By doing so, the federal government can dedicate funding to a program that will be most effective in reaching AI/AN and is best equipped to give culturally competent care.¹⁰⁴ By having a firm grasp on what seems to be a set of perennial issues surrounding the federal trust responsibility, we may be better able to overcome the turbulence of the past and move in a new direction for the future.

102. See generally Young, *supra* note 63.

103. See generally Dyste, *supra* note 6, 111-15.

104. Nw. Portland Area Indian Health Bd., *supra* note 9, at 10.

The Affordable Care Act's Negative Impact on Pre-existing Health Care Coverage for Small Businesses with Blue-Collar Workers

*Amy Michelau**

I. INTRODUCTION

The American healthcare industry has long suffered from dysfunction caused by “inefficiencies, perverse incentives, and market failures.”¹ The United States ranks among the lowest of developed countries in quality of health care, yet it spends almost twice as much money per patient.² In the United States, health care is financed principally through employment-based health insurance.³ As of June 2014 approximately 171 million Americans, or nearly two-thirds of the population, had employer-sponsored health coverage.⁴ Furthermore, in 2013 the cost of health benefits per employee averaged \$2.70 per hour.⁵

Employee access to employer health care coverage varies substantially according to the size of the employer.⁶ Small businesses have historically faced challenges in providing health care coverage.⁷ The reluctance of small

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1. Charles P. Litchfield, *Taxing Youths: Health Care Reform Writes a Costly Prescription that Leaves the Young and Healthy Paying the Bill*, 85 S. CAL. L. REV. 353, 355 (2011).

2. *Id.*

3. Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 886 (2011).

4. DEVON M. HERRICK, NAT'L CTR. FOR POLICY ANALYSIS, THE EFFECTS OF THE AFFORDABLE CARE ACT ON SMALL BUSINESSES 3 (2014), available at <http://www.ncpa.org/pdfs/st356.pdf>.

5. *Id.*

6. Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1942 (2014).

7. Stacey McMorrow et al., *The Effects of Health Reform on Small Businesses and Their Workers: Timely Analysis of Immediate Health Policy Issues*, URBAN INST. 2 (2011),

employers to offer health care coverage stems largely from the higher administrative costs involved and the disproportionate effects of the poor health status of just one or two employees.⁸ The potential strengths offered by small-group markets, along with the historical difficulties, made them a main target of the Patient Protection and Affordable Care Act (ACA) and healthcare reform.⁹ The ACA substantially reforms the American healthcare system, but it increases reliance on employment-based health insurance; rather than eliminating it.¹⁰

This article will first discuss the general ACA provisions applicable to small businesses. The article will then examine the substantial hardships the ACA has placed on small businesses that were previously offering satisfactory health care coverage prior to the ACA, and explore possible steps that small businesses may decide to take. This article does not attempt to postulate that the ACA is overall detrimental to the American healthcare system; it merely explores the propriety behind the assertion that small businesses already offering satisfactory health coverage pre-ACA are now forced to deal with heavy burdens. Further, this article does not attempt to claim that small employer-based health insurance must be saved in order to save the national healthcare system. Admittedly, there is no inherent reason to save the small-group insurance market unless it is an efficient and equitable means of coverage.¹¹

available at <http://www.urban.org/uploadedpdf/412349-Effects-of-Health-Reform-on-Small-Businesses.pdf>. Monahan & Schwarcz, *supra* note 6, at 1950 (In 2011, 48% of businesses with three to nine employees, 71% of businesses with ten to twenty-four employees, 85% of businesses with twenty-five to forty-nine employees, 93% of businesses with fifty to 199 employees, and 99% of businesses with more than 200 employees offered health insurance).

8. Monahan & Schwarcz, *supra* note 6, at 1942-1943 (stating “administrative costs associated with small-employer coverage are much greater . . . the poor health status of just one or two employees can disproportionately affect the cost and availability of small-employer coverage.”).

9. *Id.* at 1945.

10. Moore, *supra* note 3, at 886.

11. Allison K. Haufman, *An Optimist’s Take on the Decline of Small-Employer Health Insurance*, 98 IOWA L. REV. BULL. 113, 114 (2013).

II. ACA PROVISIONS AFFECTING SMALL BUSINESSES

The ACA addresses the previous deficiencies in employer coverage by requiring employers to make changes in health care coverage.¹² Three provisions within the ACA most directly affect small businesses: 1) an employer penalty for not providing health insurance for businesses with fifty or more employees, 2) a tax credit to increase the affordability of health insurance for businesses with fewer than twenty-five employees, and 3) small business health insurance exchanges (SHOPs) designed to increase plan options and lower costs.¹³

A. The Employer Penalty

Only employers with more than fifty full-time employees (FTEs) are subject to new financial penalties for failing to provide health care coverage to employees.¹⁴ More than 96% of U.S. businesses are exempt from the employer penalty simply because they have fewer than fifty employees.¹⁵ The remaining roughly 4% of businesses with fifty or more employees employed 72% of all workers in 2011.¹⁶ The effects of the employer penalty will be most noticeable among smaller businesses in certain industries that hover around fifty FTEs and primarily those that employ low-income employees.¹⁷

The amount of the employer penalty depends on whether an employer offers any insurance coverage, and if so, whether the coverage offered is

12. Whitney Morrisey, *Obamacare's Employer-Shared Responsibility Provision: The Impact on Employers and Employees*, 7 PHOENIX L. REV. 105 (2013).

13. SEAN LOWRY & JANE G. GRAVELLE, CONG. RESEARCH SERV., R43181, THE AFFORDABLE CARE ACT AND SMALL BUSINESS: ECONOMIC ISSUES 1 (2014), available at <http://fas.org/sgp/crs/misc/R43181.pdf>.

14. Monahan & Schwarcz, *supra* note 6, at 1948 (The current ACA definition of a "full-time employee" as one who works thirty or more hours per week differs from the traditional understanding of a full-time employee as working a minimum of forty hours per week).

15. LOWRY & GRAVELLE, *supra* note 13, at 9 (these small businesses account for roughly 27% of all U.S. workers).

16. *Id.* at 9-10 (After factoring in businesses that already provide health care coverage, less than 1% of U.S. businesses could immediately be subject to the employer penalty).

17. *Id.* at 16.

“affordable” and “adequate.”¹⁸ Individuals who are offered “affordable and adequate” employer coverage that provides “minimum value” are not eligible for tax credits or cost-sharing subsidies.¹⁹ This creates an unprecedented effect: small employers with predominantly low-income workers could actually make their employees worse off by offering health care coverage.²⁰

Although the employer penalty is designed to encourage employers to maintain or offer health coverage, opponents claim the costs of the employer penalty or related compliance costs will ultimately damage small businesses.²¹ The employer penalty may incentivize employers to take undesirable actions such as firing or avoiding hiring workers in order to stay below the ACA fifty-employee level, increasing the cost of hiring low-income workers, or reducing employee hours.²² Exemption from the employer penalty for having fewer than fifty workers creates disincentives for hiring more employees because hiring one additional employee could trigger significant costs and discourage expansion.²³ According to a survey of more than 600 small businesses, more than four in ten small business owners have delayed hiring because of concerns and uncertainty of ACA effects, and one in five small business owners decreased the number of employees.²⁴ The employer penalty poses a minor negative effect on the aggregate demand for labor until businesses can adjust to ACA regulations by lowering wages over time.²⁵

18. *Id.* at 5-6 (Under the ACA, coverage is affordable when the employee’s required plan contribution does not exceed 9.5% of his or her household income, and coverage is adequate when the plan is a 60% or greater actuarial value. If an employer does not offer affordable and adequate coverage and one or more of his or her employees receives premium credits, the monthly penalty is the lesser of one-twelfth of \$3,000 for each employee who receives credits, or one-twelfth multiplied by \$2,000 multiplied by the number of FTEs minus the first thirty employees.).

19. Monahan & Schwarcz, *supra* note 6, at 1948.

20. *Id.* at 1951.

21. LOWRY & GRAVELLE, *supra* note 13, at 1.

22. *Id.* at 13.

23. *Id.* at 8.

24. HERRICK, *supra* note 4, at 9.

25. LOWRY & GRAVELLE, *supra* note 13, at 11.

B. Tax Credits

Small employers must satisfy four requirements in order to qualify for the small-employer tax credit: 1) employers must have fewer than twenty-five FTEs, 2) the average annual wages of the employees must be less than \$50,000 per FTE, 3) the employer must maintain a “qualifying arrangement” under which the employer pays a uniform percentage of at least 50% of the premium cost for each employer-insured FTE, and 4) the credit is only available if insurance is provided through a state-sponsored insurance exchange as of 2014.²⁶ However, the maximum duration of this tax credit is only six years.²⁷ This healthcare tax credit is intended to benefit only very small employers and very low-income workers, and less than 4% of businesses that could have claimed the tax credit in 2010 actually claimed it.²⁸ Many small business owners felt that the credit was too small of an incentive, their employees could not afford their share of the premium, or the ACA rules were too complex and confusing.²⁹

C. SHOP Exchanges

Most of the theoretical benefits the ACA offers to small businesses come from the SHOP exchanges and health insurance market reforms.³⁰ Small employers seeking health coverage for qualified employees are able to use the ACA's SHOP exchanges beginning in 2014.³¹ Though SHOPS have the potential to reduce costs by pooling risk among multiple small businesses, businesses with healthy employees would likely see a rise in insurance costs

26. Moore, *supra* note 3, at 913.

27. Monahan & Schwarcz, *supra* note 6, at 1949 (From 2010 to 2013, the government provided a transitional credit available to qualifying employers of up to 35% of the employer's payment, and beginning in 2014, a credit was available of up to 50% for two consecutive years).

28. Lowry & Gravelle, *supra* note 13, at 11.

29. *Id.* at 12.

30. McMorrow et al., *supra* note 7, at 3.

31. Lowry & Gravelle, *supra* note 13, at 7.

due to increased risk-pooling with less healthy individuals.³²

Further, workers who purchase coverage through the SHOP exchanges will not be eligible for individual subsidies, and small group health insurance policies sold outside of SHOP exchanges are not allowed to adjust premiums based on health status.³³ Employer options have remained limited because SHOP exchanges are not required to carry out the “employer choice” function of enabling employers to select from a variety of coverage options until 2015.³⁴ The ACA also increases the likelihood that small employers who already offer health care coverage will elect to circumvent many ACA requirements by choosing to self-insure their health plans, thus exposing the SHOP exchanges to substantial adverse selection.³⁵ For all these reasons, it is difficult to find a financial incentive for using the SHOP exchanges.³⁶

D. Additional Rules and Regulations

The ACA places various additional burdens on employer coverage. Businesses with fifty to ninety-nine employees will see a slight increase in existing employer health costs because they are not eligible for subsidies, yet must also comply with new regulations.³⁷ Beginning in 2014, the ACA requires small-group markets to cover “essential health benefits” as defined by the Secretary of the Department of Health and Human Services.³⁸ Required essential health benefits also now include preventive services, with

32. *Id.* at 13.

33. HERRICK, *supra* note 4, at 5.

34. LOWRY & GRAVELLE, *supra* note 13, at 7.

35. Monahan & Schwarcz, *supra* note 6, at 1965 (“A self-insured plan is one in which the employer retains liability for claims, rather than transferring that liability to an insurer.”). LOWRY & GRAVELLE, *supra* note 13, at 3 (explaining that adverse selection occurs in the health insurance industry when sicker individuals seek out coverage and healthier individuals do not, thus driving up the average price of insurance).

36. HERRICK, *supra* note 4, at 5.

37. McMorrow et al., *supra* note 7, at 6.

38. Monahan & Schwarcz, *supra* note 6, at 1945, 1946 (Plans for small businesses are now required to provide essential health benefits, including emergency services, ambulatory and hospital care, prescription drugs, mental health services, and maternity benefits).

the goal of decreasing the cost of care; however, research has shown that preventive services actually increase total costs about 80% of the time.³⁹ Moreover, businesses with fifty or more employees are now required to contribute at least 60% of the cost for minimum essential coverage, which means that new plans are likely to be more expensive than previously offered coverage.⁴⁰ For these reasons, essential health benefit requirements restrict consumer choice and increase premiums.⁴¹

According to the ACA community rating provisions, in the small-group market insurers are only permitted to vary price based on age, geographic location, tobacco use, and family size.⁴² Therefore, businesses with predominantly young and thus presumably healthy workers will see an increase in coverage costs because insurers can no longer vary premiums based on health status or group size.⁴³ In addition, the historically typical age-rating ratio of five-to-one for premiums charged between old and young ages is now limited to the new age-rating band of three-to-one, so younger and healthier individuals will see further premium rate increases.⁴⁴

Furthermore, under the ACA, as of January 1, 2011, all small group plans are required to maintain a medical loss ratio (MLR) of 80%.⁴⁵ The MLR requirement restricts the profitability of health plans by strictly regu-

39. HERRICK, *supra* note 4, at 5.

40. *Id.*

41. HOUSE COMM. ON ENERGY & COMMERCE, ET AL., THE PRICE OF OBAMACARE'S BROKEN PROMISES: YOUNG ADULTS AND MIDDLE CLASS FAMILIES SET TO ENDURE HIGHER PREMIUMS AND UNAFFORDABLE COVERAGE 5, (2013), available at http://gingrey.house.gov/uploadedfiles/price_of_obamacare_broken_promises.pdf.

42. Monahan & Schwarcz, *supra* note 6, at 1945.

43. HERRICK, *supra* note 4, at 7.

44. CTRS. FOR MEDICARE & MEDICAID SERVS., REPORT TO CONGRESS ON THE IMPACT ON PREMIUMS FOR INDIVIDUALS AND FAMILIES WITH EMPLOYER-SPONSORED HEALTH INSURANCE FROM THE GUARANTEED ISSUE, GUARANTEED RENEWAL, AND FAIR HEALTH INSURANCE PREMIUMS PROVISIONS OF THE AFFORDABLE CARE ACT 4 (2014), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/ACA-Employer-Premium-Impact.pdf>.

45. Sandy Praeger, *A View From the Insurance Commissioner on Health Care Reform*, XX:2 KANSAS J. L. & PUB. POL'Y 186, 188 (2011) (explaining that MLR is the percentage of premium that goes to medical claims and activities that improve health care quality).

lating how insurers spend premium revenues.⁴⁶ The ACA also imposes \$165 billion in new taxes and fees on health plans and drug and device manufacturers, the cost of which will be passed on to consumers in the form of higher premiums.⁴⁷ Additionally, the ACA extends coverage for dependents to the age of twenty-six, which could increase premiums by increasing employer health plan enrollment.⁴⁸ Restrictions on lifetime and annual limits, and the numerous consumer protection requirements could also significantly increase the cost of administering health plans.⁴⁹

E. Grandfathering

Some small businesses were able to avoid the increased cost of ACA compliance by renewing less-expensive and non-conforming “grandfathered” plans before 2014.⁵⁰ However, the regulations surrounding the ACA’s grandfather rule implement narrow parameters for plans to retain grandfathered status, and make it almost impossible for plans to meet the requirements.⁵¹ Federal regulators developed a comprehensive list of changes that would cause plans to lose their grandfathered status; effectively ensuring that most employer health plans will quickly lose their grandfathered status after implementation of the ACA.⁵² The strategy can be viewed as a form of paternalism to persuade people to accept the new federal health insurance regime.⁵³ Two-thirds to 80% of employer plans will likely lose their grandfathered status.⁵⁴

46. Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 768 (2011).

47. HOUSE COMM. ON ENERGY & COMMERCE, ET AL., *supra* note 41, at 5.

48. Leonard, *supra* note 46, at 768.

49. *Id.*

50. HERRICK, *supra* note 4, at 5. Leonard, *supra* note 46, at 754 (The ACA codified the promise that if an individual is happy with his or her health plan, such individual would not have to change it as the “grandfather rule”).

51. Leonard, *supra* note 46, at 756.

52. *Id.* at 761.

53. *Id.* at 762.

54. HERRICK, *supra* note 4, at 6.

III. THE ACA PLACES SUBSTANTIAL BURDENS ON SMALL BUSINESSES THAT PREVIOUSLY OFFERED COVERAGE

A. Premium Increases

Most of the impact of the ACA's taxes and fees is expected to fall on small businesses in the form of higher premiums.⁵⁵ Both opponents and supporters of the ACA realize that it will significantly increase premiums.⁵⁶ A 2014 Presidential Administration report admitted that two-thirds of small businesses will likely see an increase in insurance premiums under the ACA, and more employers will face insurance cancellations or premium increases when they are forced to comply with the comprehensive ACA plan requirements.⁵⁷ Due to these changes, small businesses that are forced to purchase new policies will likely experience up to 20% higher premiums.⁵⁸

The new regulations, which limit variation based on health status and spread risk more broadly, are likely to result in a general upward pressure on average premiums.⁵⁹ This result is due in part to the fact that younger and healthier, low-income employees can no longer choose health plans that provide limited benefits in exchange for lower premiums.⁶⁰ Insurance costs rise when employers are required to provide health insurance but have limited options for low-cost plans, and thus employees are less insulated from premium increases.⁶¹ Rates in the small group market have dramatically ris-

55. Joshua Fangmeier & Marianne Udow-Phillips, *Issue Brief: Premium Cost Changes Attributable to the Affordable Care Act*, CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION 4 (Feb. 2014), available at <http://www.chrt.org/publication/premium-cost-changes-attributable-affordable-care-act/>. Douglas Holtz-Eakin, *Insurance Premiums in 2014 and the Affordable Care Act: Survey Evidence*, AM. ACTION FORUM 1 (Jan. 2013), available at http://americanactionforum.org/sites/default/files/AAF_Premiums_and_ACA_Survey.pdf (explaining that insurance premiums are driven by growth in health care spending, along with rules governing insurance rates and the price variation between individuals and employers).

56. HOUSE COMM. ON ENERGY & COMMERCE, ET AL., *supra* note 41, at 2.

57. HERRICK, *supra* note 4, at 8.

58. HOUSE COMM. ON ENERGY & COMMERCE, ET AL., *supra* note 41, at 5.

59. McMorrow et al., *supra* note 7, at 4.

60. HERRICK, *supra* note 4, at 7.

61. Ben Gitis et al., *Obamacare's Impact on Small Business Wages and Employment*, AM. ACTION FORUM 1 (Sept. 9, 2014), available at <http://americanactionforum.org/research/>

en as a result of the ACA, as evidenced by premium increases of 11% in 2014 for businesses renewing in the small group market.⁶² The contract premium cost increased 16% for small businesses with coverage through BlueCross BlueShield between 2013 and 2014.⁶³ Although the impact will vary significantly based on the employer coverage starting point, the age rating three-to-one ratio constraint, health status, and gender rating regulations have the largest impacts on the cost of health insurance for young and healthy employees.⁶⁴ Higher health premiums are the last thing that working families can afford.⁶⁵

Additionally, small business owners consistently report that the greatest business issue is increases in health insurance premiums.⁶⁶ In 2013, health insurance premium cost incurred by small businesses offering health coverage averaged \$6,721 per month.⁶⁷ Small employers pay the largest share of the premium cost for individual plans.⁶⁸ Though the increased costs are more likely to affect small employers than their employees, employees in 60% of businesses experiencing higher health insurance premium costs under the ACA still bore a portion of the increase themselves.⁶⁹ Premium price increases may also cause small employers to increasingly drop coverage, push lower-income employees into purchasing coverage through the subsidized individual exchange, and offer to reimburse the employee's non-subsidized share of the premium.⁷⁰

ObamaCares-Impact-on-Small-Business-Wages-and-Employment.

62. HERRICK, *supra* note 4, at 7.

63. *Id.*

64. Holtz-Eakin, *supra* note 55, at 3.

65. HOUSE COMM. ON ENERGY & COMMERCE, ET AL., *supra* note 41, at 2.

66. William J. Dennis, Jr., *Small Business's Introduction to the Affordable Care Act Part 1*, NAT'L FED'N OF INDEP. BUS. 16 (2013), available at <http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/ppaca/nfib-aca-study-2013.pdf>.

67. *Id.*

68. *Id.* at 14.

69. *Id.* at 18 (Another 37% of small employers surveyed by NFIB froze or reduced wages, and 30% raised selling prices to customers in order to help offset for premium increases).

70. *Id.* at 9.

The premium impact in the small group market is expected to result largely from the ACA community rating provision.⁷¹ Up to 53% of small group plans (63% of small group employees) could experience a premium rate increase of 15% largely due to the elimination of health status as a rating factor, and 89% of small employers are expected to experience a premium rate increase of 12% largely due to the elimination of group size as a rating factor.⁷² The small group premium rates will predictably increase by 20%.⁷³ Of the 17 million people receiving full coverage in the small group health market in 2012, roughly 11 million individuals are expected to see higher premiums as a result of the ACA.⁷⁴ Correspondingly, 65% of small businesses are expected to experience increased premium rates.⁷⁵

Furthermore, a 2013 survey among large health insurers covering the majority of U.S. individuals examined the ACA's impact on insurance premiums.⁷⁶ When viewed from an actuarial science perspective, the ACA benefit mandates, guaranteed issue, and rules limiting premium variation would likely raise premiums.⁷⁷ The survey concluded that the ACA promises massive rate shock to the young and healthy population and small employers, who will see dramatic increases in the cost of insurance.⁷⁸ These increases are needed to subsidize older and sicker employees, who will see declines in premium costs.⁷⁹ Simply put, any large-scale changes in the law will create winners and losers.⁸⁰ This is similar to the scenario that if the "good driver discount" in the automobile insurance industry were eliminat-

71. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 44, at 3.

72. *Id.* at 4.

73. *Id.* at 5.

74. *Id.* at 5-6 (the CMS analysis focused on the number of people with employer coverage whose premium rates are expected to change due only to the guaranteed issue, guaranteed renewability, and premium rating provisions of the ACA only).

75. *Id.* at 5.

76. Holtz-Eakin, *supra* note 55, at 2.

77. *Id.* at 1.

78. *Id.*

79. *Id.*

80. *Id.* at 2.

ed, the “good drivers” would see an increase in their rates.⁸¹

In 2006, Massachusetts became the first state in the nation to require all of its citizens to obtain health insurance.⁸² The Massachusetts plan included financial penalties that targeted individuals who did not purchase health coverage as well as employers who did not provide coverage to their employees.⁸³ In 2008, two years after the implementation of the employer mandate in Massachusetts, employers continued to experience large premium increases, with small employers seeing increases in the double digits.⁸⁴

B. Loss of Wages and Jobs

For businesses with twenty to forty-nine workers in 2014, a 1% increase in total health insurance premiums is associated with a 0.031% decrease in wages post-ACA, as opposed to an increase of 0.077% pre-ACA.⁸⁵ Similarly, businesses with fifty to ninety-nine employees saw a 0.109% decrease in wages for every 1% increase in total health insurance premiums post-ACA.⁸⁶ Total premiums in an average state have increased by 19.8% from 2010 to 2013, so the average weekly pay of \$831 to these employees in 2013 was 2.2% lower than it would have been absent the ACA.⁸⁷

ACA regulations are costing the 14.8 million employees in businesses with fifty to ninety-nine employees about \$10.8 billion annually, and costing employees of businesses with twenty to forty-nine employees about

81. *Id.* at 3, 5 (explaining that a small business comprised of young, healthy workers in a relatively inexpensive policy in Chicago, Illinois would see an estimated increase in their premiums of 144%, from \$1,685 to \$4,551).

82. Lin Lin, *All is Well in Massachusetts? Diagnosing the Effects of the 2006 Employer Mandate on Health Care Reform Efforts*, 25 J. CONTEMP. HEALTH L. & POL'Y, 406, 408 (2009).

83. *Id.* at 409.

84. *Id.* at 432.

85. Gitis et al., *supra* note 61, at 2, 5 (The AAF conducted research, using data from the Bureau of Labor Statistics and the Medical Expenditure Panel Survey released in September 2014, in order to estimate how changes in premiums relate to annual average state employment and average weekly pay in small businesses).

86. *Id.* at 5.

87. *Id.*

\$11.8 billion annually.⁸⁸ Furthermore, under the ACA, employees who work year-round for a business with fifty to ninety-nine employees lose \$935 annually and employees of businesses with twenty to forty-nine employees lose \$827.50 annually on average.⁸⁹ ACA regulations are reducing small business payouts by at least \$22.6 billion annually and small business employment by more than 350,000 jobs nationwide.⁹⁰ From a single state perspective, in Illinois employees of businesses with fifty to ninety-nine employees experienced premium increases of 23.3% and a \$1,260 decrease in annual earnings since the ACA became law.⁹¹ Further, Illinois employees of businesses with twenty to forty-nine employees experienced premium increases of 23.3% and 16,167 lost jobs since the ACA became law.⁹²

Employees of small employers generally contribute a portion of their premium, so if premiums increase, it can correctly be assumed that employee contribution will also increase.⁹³ Blue-collar workers who are constrained in their household budgets are less likely to be able to afford out-of-pocket premium costs in an employer health plan, and would likely prefer an increase in wages instead of benefits.⁹⁴ Blue-collar workers are also less likely to use their already scarce wages towards purchasing health benefits.⁹⁵ Many of these employees living paycheck-to-paycheck in order to support their families cannot afford to see a decrease in wages. Still, some employers are forced to reduce their operating costs in response to ACA compliance costs by passing on more of the added expense to workers by raising copayments or prices for dependent coverage.⁹⁶

88. *Id.* at 5, 8.

89. *Id.* at 1.

90. *Id.*

91. *Id.* at 6.

92. *Id.* at 8.

93. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 44, at 5.

94. LOWRY & GRAVELLE, *supra* note 13, at 16.

95. HERRICK, *supra* note 4, at 4.

96. *Id.* at 8.

IV. STEPS SMALL BUSINESSES MAY BE FORCED TO TAKE

Although it is not yet clear which provisions of the ACA will have the largest negative impact because regulatory guidelines have not yet been issued, there is little doubt that employers and employees are exposed to many perverse incentives under the ACA.⁹⁷ Both employers and employees can attempt to limit the ACA's financial impact, but their ways of doing so are at odds.⁹⁸ The ACA imposes effective taxes to low- and moderate-income workers.⁹⁹ Small employers with less than fifty employees may be tempted to terminate existing coverage or convert to a self-insured arrangement.¹⁰⁰

Many of the ACA's provisions do not extend to self-insured, employer-covered groups, where the risk is borne by the employer.¹⁰¹ Accordingly, self-insured plans are increasingly being marketed to small employers.¹⁰² Some small employers may decide to begin self-insuring, and thus escape ACA requirements such as community rating provisions, essential health benefits, and some taxes.¹⁰³ Historically, self-insurance has only been common with large employers, because smaller employers cannot bear the risk of incurring substantial expenses even in the event that only one or two employees become seriously ill.¹⁰⁴ Moreover, this is not an attractive option for the government either, because self-insurance threatens to undermine

97. David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669, 713 (2012).

98. Suja A. Thomas & Peter Molk, *Employer Costs and Conflicts Under the Affordable Care Act*, 99 CORNELL L. REV. 56, 59 (2013).

99. Gamage, *supra* note 97, at 670-671 ("When a law or regulation deters economic actors from the choices that they otherwise would have made, we can say that the law or regulation imposes 'effective taxes' on those choices.").

100. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 44, at 3.

101. Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 540 (2013).

102. *Id.*

103. Dennis, Jr., *supra* note 66, at 10.

104. Jost & Hall, *supra* note 101, at 546.

the ACA's small-group reforms and poses a "clear and present danger to the viability of the small-employer market."¹⁰⁵

Businesses with fewer than fifty moderate-income workers will find it less expensive to drop coverage completely and pay the penalty, rather than paying the increased ACA compliance costs.¹⁰⁶ However, many employees do not want this arrangement, as shopping for health insurance can be time-consuming and complicated for most.¹⁰⁷ A large number of Americans may simply prefer to stay with their current plan rather than expend the time, energy, and resources involved in switching.¹⁰⁸ Many small employers also do not wish to drop coverage because health care coverage has historically been viewed as a valuable tool for small businesses to recruit a qualified workforce.¹⁰⁹ Additionally, if employers stop offering adequate coverage to their low- to moderate-income employees, the budgetary costs of the exchange subsidies will be much higher than predicted.¹¹⁰ Almost any strategy that employers use to reorganize their business operations in order to avoid or comply with ACA regulations will create costs.¹¹¹

V. CONCLUSION

One of President Obama's most effective slogans in the health reform debate was, "if you like your health plan, you can keep your health plan."¹¹² However, this has not been the case.¹¹³ Sufficient evidence exists that the ACA is raising the cost of health insurance for small employers.¹¹⁴ Health insurers have been forced to change small business policies in order to

105. *Id.* at 540.

106. HERRICK, *supra* note 4, at 6.

107. Moore, *supra* note 3, at 897.

108. Leonard, *supra* note 46, at 760.

109. Lin, *supra* note 82, at 423.

110. Gamage, *supra* note 97, at 713.

111. *Id.* at 712.

112. Leonard, *supra* note 46, at 758.

113. *Id.* at 754.

114. HERRICK, *supra* note 4, at 3.

comply with the ACA's requirements and small business owners are already feeling the impact.¹¹⁵ A significant amount of the burden involved in complying with the ACA falls on businesses.¹¹⁶ Businesses that previously offered health insurance before the ACA and rely heavily on low-income workers - many of whom cannot afford to pay their share of the cost of insurance premiums - are forced to re-think their business practices.¹¹⁷ Small employers may opt to continue to offer coverage after considering employee resistance and administrative issues.¹¹⁸

The ACA makes health coverage less affordable for many by requiring insurers to take on unlimited risk, which goes against the core original objective behind health insurance at its infancy.¹¹⁹ The ACA threatens to exacerbate the healthcare system deficiencies that it ultimately set out to solve.¹²⁰ While the ACA is designed to supply money to the federal budget, one is forced to wonder whether the potential benefits to the federal budget outweigh the hardships and expansion limitations felt by the small business working class. Small businesses with less resources and smaller profit margins may not be able to survive when they cannot forecast the rising costs of health care.¹²¹

115. Dennis, Jr., *supra* note 66, at 3.

116. HERRICK, *supra* note 4, at 8.

117. Reed Abelson & Steven Greenhouse, *Small Employers Weigh Impact of Providing Health Insurance*, N.Y. TIMES (Nov. 3, 2012), available at http://www.nytimes.com/2012/12/01/business/small-employers-weigh-impact-of-providing-health-insurance.html?pagewanted=all&_r=0.

118. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 44, at 3-4.

119. HERRICK, *supra* note 4, at 7.

120. Litchfield, *supra* note 1, at 353.

121. Lin, *supra* note 82, at 421.

PPACA Abortion Restrictions and Illinois Policy

*Holly McCurdy**

I. INTRODUCTION

Just over forty years ago abortion was still illegal in the United States.¹ With the passage of the Patient Protection and Affordable Care Act (ACA) and its many requirements and restrictions in the area of abortion, it seems as though the laws of this country have come almost full circle, and the nation is regressing towards the restrictive, paternalistic policies of the not so distant past.² The Supreme Court's decision in *Roe v. Wade* decriminalized abortion and signified a giant leap in the fight for women and their right to choose and determine the course of their lives.³ Since then, however, several Supreme Court decisions and legislative efforts have operated to rescind some of those rights, effectively restricting women's access to health care and simultaneously the right to choose.⁴

Traditionally, abortion restrictions in the United States have only applied in the realm of public insurance and affected only those individuals participating in Medicaid and other federal programs that depend upon the federal

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1. *Roe v. Wade*, 410 U.S. 113, 116-19 (1973).

2. *See generally* Patient Protection and Affordable Care Act, 42 U.S.C. § 18023 (2012) (permitting states to opt out of providing abortion coverage in their exchanges, and prohibiting certain Federal credits and reductions if states choose to cover certain types of abortions).

3. *Roe*, 410 U.S. at 166.

4. *See generally* Cynthia Soohoo, *Hyde-Care for All: The Expansion of Abortion-funding Restrictions Under Health Care Reform*, 15 CUNY L. REV. 391, 401-10 (2012) (discussing the Hyde Amendment and implications of Supreme Court decisions in *Harris v. McRae*, *Beal v. Doe*, and *Maier v. Roe* as they relate to abortion rights and state and federal abortion coverage requirements).

government for health care.⁵ The requirements of the ACA effectively bring abortion coverage restrictions to an unprecedented level. The abortion coverage restrictions now apply not only to public insurance plans, but also to private insurance plans, as all plans participating in the exchanges must comply with the ACA.⁶

This article argues that although the ACA is a major advancement in health reform, bringing insurance coverage to millions of individuals who were previously uninsured, it simultaneously restricts women's access to health care by incorporating significant restrictions on abortion coverage in both public and private insurance, largely in the form of the Hyde Amendment.⁷ In the face of these restrictions, Illinois responded with policies to ensure that women will still have significant access to abortion services and coverage by excluding any restrictions on private insurance plans and placing only minimal restrictions on public insurance plans beyond those required by the ACA.⁸ Conversely, many other states opted to implement restrictions far beyond what is required by the ACA, effectively limiting women's access to health care and their constitutional right to choose abortion. These states should consider repealing their laws and implementing laws similar to those in Illinois to ensure that all women have access to health care and freedom of choice.

The first part of this article will focus on various requirements of the ACA and discuss the recent healthcare reform efforts in the United States. The second part of this article will focus specifically on abortion re-

5. *See id.* at 392.

6. *See* Nicole Huberfeld, *With Liberty and Access for Some: The ACA's Disconnect for Women's Health*, 40 *FORDHAM URB. L.J.* 1357, 1376 (2013).

7. *See* Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1418 (1976) (§ 209 of the Act describes what is commonly known as the Hyde Amendment).

8. *See generally* State Employees Group Insurance Act of 1971, 5 *ILL. COMP. STAT.* 375/6 (2003) (abortion benefits for state employees are limited to cases where an abortion is necessary to preserve the life of the pregnant woman); Illinois Public Aid Code, 305 *ILL. COMP. STAT.* 5/5-5 (2014) (listing all medical services eligible for government reimbursement).

strictions, beginning with a short historical review of the original source of federal restrictions on abortion coverage and then turning to the ACA provisions. Next, this article will discuss Illinois' response to the ACA, specifically the policies it has in place that comply with the ACA in the least restrictive manner and provide Illinois women a meaningful right to choose. Lastly, this article will demonstrate that the more restrictive states in this country should alter their policies to mirror those of Illinois to ensure women have access to health care, including abortion services.

II. THE ACA

President Barack Obama signed the ACA into law on March 23, 2010.⁹ The ACA is designed to expand access to health care coverage for individuals across the nation by making insurance more affordable and accessible.¹⁰ The ACA required all states to establish health insurance exchanges by January 1, 2014. Through these exchanges individuals will be able to enroll in public health insurance programs or purchase private health insurance, either unsubsidized or with the aid of federal subsidies.¹¹ Insurers seeking to participate in state exchanges must satisfy a set of standards to be qualified to offer plans on the exchanges.¹² The ACA requires all health plans offered on the exchanges provide minimum coverage in the form of an essential health benefits package,¹³ often referred to as "minimum essential cover-

9. Alina Salganicoff et al., *Coverage for Abortion Services and the ACA*, THE HENRY J. KAISER FAMILY FOUND. 1, (Sept. 2014), <http://files.kff.org/attachment/coverage-for-abortion-services-and-the-aca-issue-brief>.

10. *Id.*

11. Magda Schaler-Haynes et al., *Abortion Coverage and Health Reform: Restrictions and Options for Exchange-Based Insurance Markets*, 15 U. PA. J. L. & SOC. CHANGE 323, 344-45 (2012).

12. Huberfeld, *supra* note 6, at 1376.

13. Schaler-Haynes et al., *supra* note 11, at 368-70 (this package must include ambulatory services, emergency services, hospitalization, maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services).

age.”¹⁴ While the ACA mandates certain coverage, states are permitted to require and insurance companies may offer additional benefits beyond the federal requirements.¹⁵

The ACA also provides financial assistance to certain individuals who purchase a private insurance plan on the exchange.¹⁶ Recognizing that there will be individuals with income levels above the Medicaid eligibility, but who are nonetheless unable to afford a private health insurance plan without financial assistance, the federal government established a system of federal subsidies.¹⁷ Thus, individuals with incomes between 100 to 400% of the federal poverty level will be eligible for federal subsidies to cover the premium for purchasing private health insurance.¹⁸ Individuals who receive federal subsidies are required to purchase a qualified health plan from an insurer through an exchange.¹⁹

Additionally, the ACA offers states the option to expand Medicaid coverage.²⁰ For those states that opt into expansion, all adults under the age of sixty-five with incomes up to 133% of the federal poverty level will be eligible for Medicaid coverage, regardless of their reproductive or parental status.²¹ Although this expansion will provide millions of previously uninsured individuals with health insurance, it will simultaneously subject all of the newly eligible lower-income women to the restrictions imposed by the ACA, including abortion restrictions.²²

14. *Id.*

15. *Id.*

16. Patient Protection and Affordable Care Act, 42 U.S.C. § 18081 (2010).

17. Schaler-Haynes et al., *supra* note 11, at 345.

18. Huberfeld, *supra* note 6, at 1376.

19. Schaler-Haynes et al., *supra* note 11, at 345.

20. Salganicoff, *supra* note 9, at 1.

21. Huberfeld, *supra* note 6, at 1377-78.

22. *Quick Sheet: Insurance Coverage of Abortion Care*, NAT'L INST. FOR REPROD. HEALTH 1, 2 (Sept. 2012), <http://nirhealth.org/sections/publications/documents/Sept2012-quicksheet-on-abortion-coverage.pdf>.

III. ABORTION AND THE ACA

A. History of Abortion Coverage Restrictions – the Hyde Amendment

The major restriction on federal funding for abortion is the Hyde Amendment.²³ Congress passed the Hyde Amendment in 1976 as a tool to prohibit the use of federal Medicaid funds to pay for abortion services.²⁴ In its original form, the Amendment contained an exception to permit federal funding for abortions only in cases “where the life of the mother would be endangered if the fetus were carried to term.”²⁵ The specific exceptions permitting federal funding for abortions have changed over the years following its passage, and the Hyde Amendment currently in force provides an exception that permits federal funding for abortions in cases where pregnancy is the result of rape or incest, and where a woman’s life is endangered if the abortion is not performed.²⁶ Federal Medicaid dollars are prohibited from funding abortion in any other circumstances.²⁷ Nevertheless, the ACA explicitly permits the use of state-only funds to finance abortions beyond the restrictions contained in the Hyde Amendment,²⁸ as Medicaid is a jointly funded state-federal program²⁹

B. ACA Abortion Restrictions

Traditionally, abortion coverage was primarily restricted within the realm of public insurance, especially under Medicaid or within other groups that rely on the federal government for health care, such as federal employ-

23. Schaler-Haynes et al., *supra* note 11, at 337.

24. Soohoo, *supra* note 4, at 392.

25. Schaler-Haynes et al., *supra* note 11, at 339.

26. *Id.*

27. Lisa C. Ikemoto, *Abortion, Contraception, and the ACA: The Realignment of Women’s Health*, 55 *How. L.J.* 731, 760 (2012).

28. Schaler-Haynes et al., *supra* note 11, at 338.

29. Ctrs. for Medicare & Medicaid Servs., *Financing and Reimbursement*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html> (last visited October 26, 2014).

ees and military personnel.³⁰ Prior to the passage of the ACA, an estimated 87% of private insurance plans covered abortion services.³¹ However, with the restrictions imposed by the ACA that percentage is all but guaranteed to decrease, perhaps drastically, because the restrictions on federal funding of abortion services now apply to all public and private insurance plans participating in the exchanges.³²

Although the ACA neither prohibits qualifying insurance plans from covering abortions nor requires them to cover abortions,³³ it explicitly states that abortion services are excluded from the list of essential health benefits the plans are required to offer.³⁴ In other words, health insurers on the exchanges are not required to offer abortion coverage. Furthermore, each marketplace must include at least one plan that does not cover abortion services beyond those that are federally funded.³⁵

The Hyde Amendment abortion restrictions affect any private insurance plan purchased on an exchange. An individual who qualifies for federal subsidies may purchase a private insurance plan on the exchange. Yet the ACA forbids the use of federal subsidies to fund abortion services beyond those permitted by the Hyde Amendment.³⁶ As such, any health plan participating on the exchanges that offers such abortion coverage must collect two separate premium payments from all enrollees, regardless of whether or not the individual enrollee is receiving federal subsidies.³⁷ One payment goes towards abortion benefit services and the other is for the value of all over covered services.³⁸ This payment scheme unnecessarily burdens an unsubsidized enrollee by requiring them to make multiple payments for one

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30. Soohoo, *supra* note 4, at 392.
 31. Huberfeld, *supra* note 6, at 1363.
 32. *Id.* at 1374.
 33. Schaler-Haynes et al., *supra* note 11, at 347.
 34. Salganicoff, *supra* note 9, at 4.
 35. *Id.*
 36. Huberfeld, *supra* note 6, at 1384.
 37. Salganicoff, *supra* note 9, at 3.
 38. *Id.*

plan.³⁹ Subsidized enrollees, who are by definition already lower-income individuals because they are eligible for federal subsidies, may also be significantly burdened.⁴⁰ For lower-income individuals the two-payment system means they must pay for abortion services out-of-pocket while the payment for remaining health benefits covered by the health plan will be made using the federal subsidies.⁴¹

The two-payment collection scheme is designed to ensure that all federal funds are segregated from personal funds, as insurance companies may only use personal funds from enrollees to cover abortion services.⁴² To highlight the importance of segregating federal funds, President Obama issued an executive order just one day after the ACA became law.⁴³ The purpose of this executive order was to “establish a comprehensive, Government-wide set of policies and procedures”⁴⁴ designed to enforce the Hyde Amendment restrictions and ensure that federal funds are not used for abortion services except where permitted.⁴⁵

The ACA does not preempt any state law that either prohibits or requires coverage or funding of abortion,⁴⁶ however it explicitly permits states to prohibit abortion coverage in the policies offered on their insurance exchanges.⁴⁷ As of October 2014, twenty-five states enacted laws prohibiting such coverage.⁴⁸ Some states⁴⁹ went to the extreme and implemented bans on all private insurance coverage of abortion services, regardless of whether

39. See Schaler-Haynes et al., *supra* note 11, at 326.

40. See Salganicoff, *supra* note 9, at 7.

41. Huberfeld, *supra* note 6, at 1384.

42. *Id.*

43. Schaler-Haynes et al., *supra* note 11, at 353.

44. *Id.* at 354.

45. *Id.*

46. *Id.* at 352.

47. Soohoo, *supra* note 4, at 393.

48. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, GUTTMACHER INST. 1 (Dec. 1, 2014), http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.

49. See *id.* at 1-2 (as of December 1, 2014, nine states (Idaho, Kansas, Kentucky, Michigan, Missouri, Nebraska, North Dakota, and Oklahoma) restrict insurance coverage of abortion in all private insurance plans).

the policies are sold on the state exchange or not.⁵⁰ Conversely, no states require abortion coverage in private health insurance policies,⁵¹ and the ACA does not require the exchanges to offer at least one plan that includes abortion coverage.⁵² Additionally, the ACA mandates that health plans participating in the exchanges are prohibited from discriminating against any individual health care provider or healthcare facility “because of its unwillingness to provide, pay for, cover, or refer for abortion.”⁵³ Yet, there is no equivalent protection offered for those providers and facilities that do cover, pay, or refer patients for abortion.⁵⁴

IV. ILLINOIS’ RESPONSE TO THE ACA

A. Abortion in Illinois

Abortion is an incredibly common medical procedure in the United States⁵⁵ and is a form of health care for women.⁵⁶ It is estimated that “by the time they reach age 45, three in ten American women will have had an abortion.”⁵⁷ In 2011 alone, nearly 45,000 women in Illinois obtained an abortion.⁵⁸ This amounts to a rate of approximately seventeen abortions per one thousand women of reproductive age in Illinois.⁵⁹ These statistics illustrate just how many women in Illinois elect to have abortions annually, and furthermore, how many women will have their access to health care restricted by the ACA requirements, whether they are covered by the Illinois’ Medicaid program or purchasing insurance on the state exchange.

50. Soohoo, *supra* note 4, at 394.

51. Schaler-Haynes et al., *supra* note 11, at 352.

52. *Id.* at 353.

53. Ikemoto, *supra* note 27, at 759.

54. Schaler-Haynes et al., *supra* note 11, at 353.

55. *Quick Sheet: Insurance Coverage of Abortion Care*, *supra* note 22, at 1.

56. *Id.* See also Huberfeld, *supra* note 6, at 1362-63 (“Abortions may be performed for a number of medical reasons.”).

57. *Quick Sheet: Insurance Coverage of Abortion Care*, *supra* note 22, at 1.

58. *State Facts About Abortion: Illinois*, GUTTMACHER INST. 1 (2014), <http://www.guttmacher.org/pubs/sfaa/pdf/illinois.pdf>.

59. *Id.*

B. Illinois Abortion Coverage Policies as Compared to Other State Policies

In spite of the many restrictions the ACA imposes on access to abortion, Illinois responded with several policies that help preserve women's access to health care.⁶⁰ Unlike many other states, Illinois did not place any additional restrictions on abortion coverage beyond those required by the ACA in the context of private insurance,⁶¹ and maintains minimal restrictions on its state Medicaid program.⁶² The policies in place in Illinois are essential to women's access to health care and their corresponding right to choose. States like Kentucky and North Dakota maintain much more restrictive abortion laws and should adopt policies similar to Illinois.⁶³ States restricting women's right to choose should consider altering their policies in order to ensure that women are provided the greatest access to health care and the right to choose an abortion.

Illinois does not limit its Medicaid coverage of abortions to only those permitted by the Hyde Amendment.⁶⁴ Illinois is one of twenty-eight states, including the District of Columbia, which opted to expand Medicaid.⁶⁵ As a result of the Medicaid expansion, thousands of low-income women in Illinois will now be eligible for Medicaid coverage,⁶⁶ but they will also be subject to the abortion restrictions imposed by the Hyde Amendment.⁶⁷ Fortunately, the ACA provides that states may use state-only funds to finance

60. See Salganicoff, *supra* note 9, at 8.

61. *Id.* at 4.

62. *State Policies in Brief: State Funding of Abortion Under Medicaid*, GUTTMACHER INST. 1-2 (Nov. 1, 2014), http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.

63. See *State Policies in Brief: Restricting Insurance Coverage of Abortion*, *supra* note 48 at 1-2.

64. *State Funding of Abortions Under Medicaid*, THE HENRY J. KAISER FAMILY FOUND. 1 (July 1, 2014), <http://kff.org/medicaid/state-indicator/abortion-under-medicaid/>.

65. *A 50-State Look at Medicaid Expansion: 2014*, FAMILIESUSA (updated Sept. 9, 2014), <http://familiesusa.org/product/50-state-look-medicaid-expansion-2014>.

66. U.S. Dep't of Health & Human Servs., *How the Health Care Law is Making a Difference for the People of Illinois*, HHS.GOV/HEALTHCARE (Sept. 22, 2014), <http://www.hhs.gov/healthcare/facts/bystate/il.html>.

67. *Quick Sheet: Insurance Coverage of Abortion Care*, *supra* note 22, at 2.

abortions in their Medicaid programs beyond the Hyde exceptions.⁶⁸ Illinois extends coverage to fund medically necessary abortions as well,⁶⁹ including instances where a woman's mental or physical well-being is endangered by her pregnancy.⁷⁰ Illinois is one of seventeen states that uses state funds to finance such abortions.⁷¹ In 1994, a state court held the Illinois constitution requires the state Medicaid program to cover medically necessary abortions even though the federal government will not provide reimbursement for those services.⁷² Even still, the reality is that these restrictions weigh heaviest upon Medicaid-insured women because they have the least available funds to finance any abortion that falls outside of Illinois coverage.⁷³

In the area of private insurance, both on and off the state exchange, Illinois equally responded with unrestrictive policies related to abortion coverage.⁷⁴ The U.S. Department of Health and Human Services reports that over 217,000 individuals in Illinois selected a marketplace plan, 53% of whom were female.⁷⁵ Thus, a significant number of Illinois women will be subject to ACA restrictions but will nevertheless find a greater degree of choice in Illinois than in other more restrictive states, because Illinois did not place any restrictions on abortion coverage in private insurance plans.⁷⁶ The Illinois policies operate to maintain women's access to health care and ensure that women purchasing private insurance on the exchange will not be bur-

68. Schaler-Haynes et al., *supra* note 11, at 338.

69. *State Policies in Brief: State Funding of Abortion Under Medicaid*, *supra* note 62, at 2.

70. See Soohoo, *supra* note 4, at 410. See also Schaler-Haynes et al., *supra* note 11, at 328 (explaining that medically necessary abortions are generally defined as those that are necessary to protect the physical or mental health of the woman).

71. *State Funding of Abortions Under Medicaid*, *supra* note 64.

72. Soohoo, *supra* note 4, at 410 (referring to *Doe v. Wright*, No. 91-CH-1958, slip op. (Ill. Cir. Ct. Dec. 2, 1994), holding that restriction on abortion coverage violated the Illinois Constitution).

73. See *Quick Sheet: Insurance Coverage of Abortion Care*, *supra* note 22, at 2.

74. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, *supra* note 48, at 2.

75. U.S. Dep't of Health & Human Servs., *supra* note 66.

76. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, *supra* note 48, at 2.

dened with any restrictions beyond those imposed by the federal government.⁷⁷

The only restrictive abortion coverage policy Illinois currently has in place is the restriction on insurance policies for public employees.⁷⁸ In this case, abortion coverage is limited to life endangering pregnancies, but Illinois provides these women the option to purchase additional coverage through a separate rider at additional costs.⁷⁹ While it will cost more, this option ensures that women will still have the choice to obtain abortion coverage.

In sharp contrast to Illinois abortion policies, a significant number of states have implemented various laws severely restricting women's rights to access health care by limiting abortion coverage. For example, while Kentucky and North Dakota opted to expand their state Medicaid programs and extended insurance coverage to thousands of individuals,⁸⁰ they limited abortion coverage only to situations permitted by the Hyde Amendment.⁸¹ This effectively ensures that low-income individuals enrolled in the state Medicaid program are required to pay for additional abortion services out-of-pocket.⁸² Such individuals generally have the least available means to do so. These two states went a step further and enacted a ban on abortion coverage that extends to all private insurance plans sold within the respective states.⁸³ Limiting abortion coverage more severely than the Hyde Amendment, Kentucky and North Dakota only permit private insurance coverage in cases when the life of the woman is in danger.⁸⁴ While there is an option

77. *Id.*

78. State Employees Group Insurance Act of 1971, 5 ILL. COMP. STAT. 375/6 (2003).

79. *Id.*

80. *A 50-State Look at Medicaid Expansion: 2014*, *supra* note 65.

81. *State Policies in Brief: State Funding of Abortion Under Medicaid*, *supra* note 62, at 1-2.

82. *See* Huberfeld, *supra* note 6, at 1381.

83. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, *supra* note 48, at 2.

84. *Id.*

to purchase a separate rider for coverage in these two states, this option has not proven effective in providing women with any abortion coverage.⁸⁵

As stated by Blue Cross Blue Shield representatives from North Dakota and Kentucky, this is because very few citizens are reportedly aware of the option with no members purchasing the rider.⁸⁶ Consequently, most women in these states seeking abortion services must pay out-of-pocket⁸⁷ despite the fact that the aim of the ACA is to increase healthcare coverage for individuals across all income levels.⁸⁸ The laws of Kentucky and North Dakota operate to severely restrict access to coverage and as such these states and others like them should alter their laws to mirror those in Illinois where the laws are significantly less restrictive.⁸⁹

V. RECENT COURT DECISION RESPONDING TO A RESTRICTIVE STATE ABORTION LAW

Not only did Illinois respond to federal action with unrestrictive abortion coverage policies, but some courts also took a similar position in regard to state actions attempting to restrict abortion services.⁹⁰ A recent Seventh Circuit Court of Appeals decision supports this notion.⁹¹ In 2012 the court upheld a preliminary injunction to block a newly enacted Indiana law, which provides that state agencies may not enter into a contract or make a grant to any entity that performs abortions or maintains or operates a facility where abortions are performed.⁹² The law cancelled any existing contracts with abortion providers.⁹³ As a provider of abortion services, Planned Parenthood of Indiana was directly affected because the law prevented it

85. Huberfeld, *supra* note 6, at 1385.

86. *Id.* at 1386.

87. Salganicoff, *supra* note 9, at 6.

88. *Id.* at 1.

89. *See id.* at 8.

90. *Planned Parenthood of Indiana v. Comm'r of Indiana State Dep't. of Health*, 699 F.3d 962, 969-70 (7th Cir. 2012).

91. *Id.*

92. *Id.*

93. *Id.*

from receiving any state-administered funds, including Medicaid reimbursement, for services unrelated to abortion.⁹⁴ Planned Parenthood challenged this law, arguing it violated a Medicaid requirement that Indiana must comply with in order to receive federal Medicaid reimbursement.⁹⁵ This “free choice of provider” requirement provides that all state Medicaid plans must provide any Medicaid beneficiary the option to obtain medical assistance from any institution qualified to perform the service or services required.⁹⁶

The Court held that a state could not interfere with an individual’s choice except when it determines a provider is not qualified.⁹⁷ The Court strictly defined “qualified” to mean capable of performing medical services needed in a professionally competent, safe, legal, and ethical manner, and held that Planned Parenthood is qualified under this definition.⁹⁸ In upholding the grant, the Court found that Indiana’s law excluded a class of providers from Medicaid funds for reasons unrelated to the provider’s qualifications, and held Planned Parenthood was likely to succeed in its claim that the law violates the Medicaid free choice of provider requirement.⁹⁹ This decision demonstrates that while the ACA granted states significant autonomy in determining the amount and type of abortion coverage they will permit,¹⁰⁰ the courts maintain the power to impose restrictions on state laws that impermissibly discriminate against abortion providers and operate to severely limit Medicaid-insured women’s choice to access a qualified healthcare provider.

94. *Id.* at 971.

95. *Id.*

96. *Id.* at 969.

97. *Id.* at 981.

98. *Id.* at 978.

99. *Id.* at 980-81.

100. *See* Ikemoto, *supra* note 27, at 758-61 (discussing how the ACA does not preempt state laws requiring or prohibiting abortion coverage in private insurance and permission of state Medicaid programs to fund abortions beyond Hyde Amendment). *See also* Huberfeld, *supra* note 6, at 1384 (discussing how the ACA permits states to prohibit abortion coverage and private insurers to choose whether or not to offer abortion coverage).

VI. CONCLUSION

The myriad of requirements the ACA imposes on both abortion services and abortion coverage severely restricts women's access to health care and specifically, the right to choose an abortion.¹⁰¹ In an unprecedented move, the federal government declared it would not only govern abortion coverage restrictions in the public insurance sphere, but in the private sphere as well.¹⁰² Women dependent upon public insurance coverage have long been subjected to the federal restrictions on abortion coverage under the Hyde Amendment, and the ACA continues to impose these restrictions on women who choose to purchase private insurance on the exchanges.¹⁰³ This is a substantial burden on both private insurers and women purchasing insurance that covers abortion on the exchanges because all payments must now be segregated to ensure no federal subsidies are unlawfully used to pay for abortion services.¹⁰⁴ Opponents argue this tactic will simply discourage private insurers from offering abortion coverage altogether because of the difficulty and administrative burden required to maintain segregated accounts.¹⁰⁵

Despite such complex restrictions and requirements, Illinois took steps in the right direction to ensure women still have a meaningful choice. Unlike many other states, Illinois did not implement any policies to further restrict abortion coverage in private insurance plans, on or off the exchanges,¹⁰⁶ nor did it limit Medicaid abortion coverage to the Hyde Amendment excep-

101. See generally Huberfeld, *supra* note 6, at 1375-84 (discussing the development of exchanges under the ACA, the expansion of Medicaid, and coverage requirements for participation on exchanges, as well as the particular restrictions on abortion coverage in both public and private insurance).

102. *Id.* at 1374.

103. Ikemoto, *supra* note 27, at 760-61.

104. *Quick Sheet: Insurance Coverage of Abortion Care*, *supra* note 22, at 2.

105. Soohoo, *supra* note 4, at 417-18.

106. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, *supra* note 48, at 2.

tions.¹⁰⁷ The laws implemented by the federal government are essentially the only laws that place restrictions upon women's right to choose, and access abortion services and coverage in Illinois. Compared to many other states, Illinois laws and policies regarding abortion coverage are fairly unrestrictive. The states with more restrictive abortion coverage laws, such as Kentucky and North Dakota, should alter their policies and model them after those of Illinois. Such a change will increase women's access to health care across the nation and result in the least restrictive abortion laws in the face of the most federally restrictive law of all, the ACA and its incorporation of the Hyde Amendment.

107. *State Policies in Brief: State Funding of Abortion Under Medicaid*, *supra* note 62, at 2.

The Risk Corridor Program: A Funding Issue

*Christopher MacKenzie**

I. INTRODUCTION

Since its implementation, the Affordable Care Act (ACA) has simplified the process for United States residents with preexisting conditions to obtain health insurance coverage.¹ As a result, insurers' inability to deny coverage to people with preexisting conditions, coupled with tax credits for low and medium income individuals, drove the increase in insurance coverage amongst these two demographics.² Under the ACA, insurance companies must sell policies to everyone, regardless of medical history³, thus increasing the likelihood that insurance companies could be stuck footing the bill for unhealthy patients.⁴

In order to ensure that insurance companies would not be stuck footing the bill, the risk corridor program was implemented to protect insurers from the risk of insuring high-risk individuals with preexisting conditions and to

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1. EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS THE KAISER FAMILY FOUND. 1 (2014), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf> ("As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions. These aspects . . . along with tax credits for low and middle income people . . . makes it easier for people with preexisting conditions to gain insurance coverage.").

2. *Id.*

3. Patient Protection and Affordable Care Act, Pub L. 111-148, Title I, § 1342, (2010) (Codified at 42 U.S.C.A Section 18062).

4. Louise Radnofsky & Jennifer Corbett Dooren, *Explaining the 'Risk Corridors,' The Next Obamacare Issue*. The Wall Street Journal, January 22, 2014, *available at* <http://blogs.wsj.com/washwire/2014/01/22/explaining-risk-corridors-the-next-obamacare-issue/>.

keep premiums low.⁵ This article argues that while the risk corridor program provides the security for insurers to sustain high-risk individuals under the ACA, Congress failed to properly fund the program and therefore, the risk corridor program is unconstitutional. Part II of this article will discuss the risk corridor program, the major players involved, and the program's current implementation. Part III will examine the arguments regarding why funding for the risk corridor program is unconstitutional without proper Congressional funding. Next, Part IV will explore the arguments for constitutionality in funding the risk corridor program and why these arguments are flawed. Lastly, Part V will discuss the impact the risk corridor program has on the health insurance industry and the possible long-term success or failure of the ACA.

II. THE RISK CORRIDOR PROGRAM AND ITS CURRENT IMPLEMENTATION

The purpose of the federally funded risk corridor program is to shift the costs from insurers who overestimate their risk to insurers who underestimate their risk.⁶ The federal government created the risk corridor program as one of the ACA's mandates; it went into effect in 2014 and will continue through 2016 as a tool to curtail cost uncertainty for health care insurance providers.⁷ The risk corridor program's rules are based on the percentage of the qualified health plan's "allowable costs" to its "target amount."⁸

5. THE KAISER FAMILY FOUND., *supra* note 1, at 4. ("The ACA's risk adjustment, reinsurance, and risk corridor programs are intended to protect against the negative effects of adverse selections and risk selection, and also work to stabilize premiums, particularly during the initial years of the ACA implementation").

6. AMERICA'S HEALTH INS. PLANS, *Affordable Care Act Premium Stabilization Programs: How Reinsurance, Risk Corridors, and Risk Adjustments Protect Consumers*, AHIP 2 (2013), available at <http://www.ahipcoverage.com/wp-content/uploads/2013/11/ACA-Premium-Stabilization-Programs-3.pdf>.

7. *Id.*

8. Alden J. Bianchi, *Premium Stabilization*, 2012-17 N.Y.U. Rev. L. Empl. Ben. 17.07 ("Allowable costs for this purpose mean an amount equal to the total medical costs, which include clinical costs, excluding allowable administrative costs (i.e., costs for the administration and operation of the health insurance issuer) paid by the QHP issuer in providing benefits covered by the QHP. Target amount means the amount equal to the total premiums incurred by the QHP, including any premium tax credits or financial assistance from any

The risk corridor program temporarily eases risk between the old and new insurance marketplaces.⁹ Specifically, the risk corridor program attempts to create a more stable market by limiting the volatility in the individual and small group markets.¹⁰ For each year of the risk corridor program, both the federal government and the insurance companies will share the risk of the insurance plans.¹¹ While the risk corridor program started in 2014, the proposed funds will not be collected or paid to the health insurance companies until 2015.¹² The government decided to implement this limited time frame because the risk corridors are most appropriate during the first few years of the ACA, when less expenditure data is available.¹³

III. AN ARGUMENT THAT RISK CORRIDOR FUNDING IS UNCONSTITUTIONAL

Payments made by the Department of Health and Human Services (HHS) to qualified health plans under the ACA require a separate congressional appropriation for those funds.¹⁴ The Secretary of HHS is a federal officer

governmental program, reduced by allowable administrative costs of the health insurance issuer.”).

9. AM. ACADEMY OF ACTUARIES, FACT SHEET: RISK SHARING MECHANISMS THE 3RS (RISK ADJUSTMENT, RISK CORRIDORS, AND REINSURANCE) EXPLAINED 2 (“An objective of risk corridors is to encourage health insurance competition by limiting the risk for insurers entering the exchange market during the early years of implementation. This provision applies to qualified health plans (QHPs) in the individual and small group markets.”).

10. AMERICA’S HEALTH INS. PLANS, *supra* note 5, at 1. *See Also*, CMS Final Rule, cms.gov 3 (“The overall goal . . . is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets.”).

11. AMERICA’S HEALTH INS. PLANS, *Id.* at 2. (“If the amount a health plan collects in premiums exceeds their medical expenses by a certain amount, the plan will make a payment to the federal government. If premiums fall short of their target, the risk corridor program transfers a portion of this shortfall to the plan.”).

12. Letter from William Schultz, Gen. Counsel, Department of Health and Human Services, to Julia C. Matta, Assistant Gen. Counsel for Appropriations Law, Department of Health and Human Services (May 20, 2014), *available at* <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20140619HHS-GAOResponse.pdf>.

13. Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act, The American Academy of Actuaries 4 (2011). (“As more data becomes available on the health spending patterns of the newly insured, the ability to set premiums accurately should increase, thereby reducing the need for risk corridors.”), *available at* http://www.actuary.org/files/Risk_Adjustment_IB_FINAL_060811.pdf.

14. ENERGY & COMMERCE COMMITTEE, *HHS Ignores Rule of Law to Transfer Billions of Dollars to Insurers Through PPACA Risk Corridor Program* (2014), *available at*

who ensures the health and well-being of the nation.¹⁵ An officer or employee of the United States cannot make a payment using federal governmental funds unless Congress issues a specific appropriation.¹⁶ The Government Accountability Office (GAO) interpreted an appropriation to consist of both a direction to pay and the specified source of funds.¹⁷ While the ACA allows the Secretary of HHS to pay directly to the designated insurance companies, the statute does not specify exactly where those payments are to be made from.¹⁸ Therefore, the Secretary of HHS has the discretion to make payments but does not have any money to make the payments with.¹⁹

It is possible that there is a valid appropriation in a different Congressional statute, such as the annual appropriation process.²⁰ However, it is too soon to know because the payments for the risk corridor program will not be made until 2015 and there is no proposed presidential budget or any pending appropriation bills at this time.²¹ Recently, the GAO found that

<http://energycommerce.house.gov/press-release/hhs-ignores-rule-law-transfer-billions-dollars-insurers-through-ppaca-risk-corridor>.

15. *HHS Leadership*, HHS.Gov, <http://www.hhs.gov/about/leadership/leaders.html#top> (last visited October 24, 2014).

16. Antideficiency Act, 31 U.S.C. §1341 (2004) Limitations on Expending and Obligating Amounts (“An officer or employee of the United States government or the District of Columbia government may not . . . make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation [or] involve either government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law.”).

17. Memorandum from Edward C. Liu, legislative attorney, Congressional Research Service, to House Energy and Commerce Committee (Jan. 23, 2014) *available at* <https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/20140123CRSMemo.pdf>, *see also* GOA 1 Principles of Federal Appropriations Law 2-16, 2-17 (2004) *available at* <http://www.gao.gov/assets/210/202437.pdf> (“If the statute contains a specific direction to pay and a designation of the funds to be used. . . then this amounts to an appropriation. . . the designation of a source of funds without a specific direction to pay is also not an appropriation.”).

18. Patient Protection and Affordable Care Act, *supra* note 3.

19. *Id.*

20. *See generally* Am. Council on Education, *A Brief Guide to the Federal Appropriations Process* (2014), *available at* <http://www.acenet.edu/news-room/Pages/A-Brief-Guide-to-the-Federal-Budget-and-Appropriations-Process.aspx>.

21. Memorandum from Legislative Attorney, Congressional Research Service, to Senate Budget Committee (May 2, 2014), *available at* <http://www.budget.senate.gov/>

HHS might not receive the proper appropriations for funding in 2015.²² This is significant because without funding in the presidential budget or an appropriation bill in 2015, the risk corridor program will lack proper funding.

Without a congressional appropriation for the funding of the ACA's risk corridor program to Secretary of the HHS, the program is simply unconstitutional.²³ Section 1342 of the ACA provides that under certain circumstances HHS "shall pay" specified amounts to participating plans.²⁴ If Congress specified to which source the payments were to be made in Section 1342 of the ACA, then there would have been a valid appropriation of Congressional funds.²⁵ However, this distribution and specification did not occur.²⁶

The amounts received from the qualified health plans cannot be used as a revolving fund to make the payments to the qualified health insurers.²⁷ A revolving fund is a "fund that conducts continuing cycles of businesslike activity, in which the fund charges for the sale of the products or services and uses the proceeds to finance its spending, usually without requirement of annual appropriations."²⁸ Advocates for the constitutionality of the risk corridor program claim that the program creates a revolving fund with its own collection from the insurers and then administers the money. However, there needs to be direct statutory authority for a federal department to ad-

republican/public/index.cfm/files/serve/?File_id=bb651aa1-bba4-443a-b4a1-f7d0e0acb30b.

22. The Healthcare Payer News, *The Risk Corridor Funding Paradox*, October 2, 2014 ("HHS may not get the appropriations for risk corridor payments in fiscal year 2015—when the agency intends to administer this year's profit-loss sharing—and yet the payments have still been signed into contract with private insurers") <http://www.healthcarepayernews.com/content/risk-corridor-funding-paradox#.VEqDYmRdWAQ>.

23. Liu, *supra* note 17, at 3.

24. Shultz, *supra* note 12, at 2.

25. Liu, *supra* note 17, at 1.

26. *Id.*

27. *Id.* at 3.

28. Tax Policy Center, Urban Institute and Brookings Institution (2014), *available at* <http://www.taxpolicycenter.org/taxtopics/budget/concepts.cfm#r>.

minister a revolving fund.²⁹ The ACA does not give direct statutory authority to HHS to run a revolving fund.³⁰

Therefore, the funding of the risk corridor program is unconstitutional through a revolving fund without standalone legislation or in an annual appropriation act.³¹ As is the case with any specific appropriation needed for funding of a program, the same goes for funding a program with a revolving fund.³² HHS has no authority to administer a revolving fund without a proper appropriation from Congress and in order for this federal program to have constitutional funding there needs to be a Congressional appropriation in the fiscal year 2015.³³

IV. AN ARGUMENT FOR THE CONSTITUTIONALITY OF FUNDING THE RISK CORRIDORS

The first argument detailing why the funding for the ACA's risk corridor program is constitutional rests upon the long-standing federal precedent highlighting how risk corridor programs have been implemented in the past when the market changes, leaving health insurers unsure about the risks they will face in the future and how to price their products.³⁴ The funding for these federal programs came from a congressional appropriation.³⁵

The National Flood Insurance Program, the Terrorism Risk Insurance Act of 2002, and the Medicare Part D Drug Plan are examples of how the federal government covered the risk of private insurers in order to make the

29. ROBERT WOOD JOHNSON FOUND., RISK CORRIDORS. THE ACA'S PREMIUM STABILIZATION PROGRAMS ENCOURAGE INSURERS TO PARTICIPATE IN EXCHANGES BY ELIMINATING UNPREDICTABILITY AROUND NEW ENROLLEES 4 (2014), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_118.pdf; see also Liu, *supra* note 17 ("An agency may not create a revolving fund absent specific authorizing legislation. In the absence of any specific directions, federal law requires such amounts to be deposited in the General Fund of the Treasury, from which they may be further appropriated by Congress.").

30. Patient Protection and Affordable Care Act, *supra* note 3.

31. Liu, *supra* note 17, at 3.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

insurers viable to a changing market.³⁶ Since its implementation, the National Flood Insurance Program has allowed private insurers to offer flood insurance to individuals without the costly risk.³⁷ Furthermore, the Terrorism Risk Insurance Act of 2002 has allowed commercial insurers to offer risky terrorism insurance to private businesses without large premiums.³⁸ In the health care realm, the Centers for Medicare & Medicaid Services (CMS) administers a risk corridor program for Medicare Part D sponsors in order to reduce some of the risk in administering this federally funded program.³⁹ The ACA's risk corridor program is modeled after the risk corridor program for Medicare Part D.⁴⁰

All three of these programs include some type of risk sharing from the federal government and some type of specific congressional appropriation of funds for their implementation.⁴¹ However, with the risk corridor program there is no specific appropriation from Congress.⁴² Therefore, the risk corridor program shares similarities with the National Flood Insurance Program, the Terrorism Risk Insurance Act of 2002, and the Medicare Part D Drug Plan only in substantial purpose and not constitutional underpinnings.

The second main argument for constitutionality of the risk corridor program is that HHS has proper legal authority to administer funds to insurers

36. TIMOTHY S. JOST, THE OPERATION OF THE AFFORDABLE CARE ACT'S RISK CORRIDOR PROGRAM 2 (House Committee on Oversight and Government Reform, 2014) available at <http://oversight.house.gov/wp-content/uploads/2014/02/Jost-Statement-ObamaCare-Insurance-COMLETE.pdf>.

37. *Id.*

38. *Id.*

39. America's Health Ins. Plans, *supra* note 5, at 2 ("CMS administers a risk corridor program in which Part D sponsors share risk above and below predetermined payment-to-cost ration thresholds established by law. The risk corridors have broadened over time, meaning Part D sponsors are more likely to be at full risk than was true during the initial years of the program.").

40. Letter from Sylvia M Burwell, The Secretary of Health and Human Services, Department of Health and Human Services to Jeff Session, United States Senator, United States Senate (June 18, 2014), available at <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20140619HHSResponse.pdf>.

41. Jost, *supra* note 36, at 2.

42. Liu, *supra* note 17.

through the program because of Section 1342 of the ACA and the CMS Program Management (PM) appropriation for the fiscal year 2014.⁴³ There is no dispute that Section 1342 of the ACA grants authority to HHS to establish and administer a temporary risk corridor program beginning in 2014 and going through 2016.⁴⁴ The argument is that the language in Section 1342 itself gives the HHS proper authority to collect these fees from the insurers and then properly fund the program.⁴⁵ Furthermore, the PM for the fiscal year 2014 states, “such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019.”⁴⁶ The argument is that this, in itself, acts as qualified appropriation by Congress for the funding of the program.

While the PM appropriation would have been available for fiscal year 2014, HHS intends to begin collections and payments to the private insurers under the risk corridor program in 2015.⁴⁷ However, for funds to be available for this purpose, PM for fiscal year 2015 must contain similar language to PM for fiscal year 2014.⁴⁸ This has not occurred to date and most likely will not occur without a cooperating Congress.⁴⁹ Therefore, PM appropriation to HHS for the fiscal year 2014 cannot be used as a proper funding for the risk corridor program because HHS is going to distribute the payment to the insurers in 2015 and there has not been a PM appropriation for fiscal

43. Schultz, *supra* note 12.

44. Patient Protection and Affordable Care Act, *supra* note 3, (“The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan’s aggregate premiums.”).

45. Schultz, *supra* note 12, at 2.

46. *Id.*

47. Letter from Susan Poling, General Counsel, U.S. Government Accountability Office, to The Honorable Jeff Sessions and the Honorable Fred Upton (Sept. 30, 2014), *available at* <http://www.gao.gov/assets/670/666299.pdf>.

48. *Id.*

49. *Id.*

year 2015.⁵⁰

V. RISK CORRIDOR IMPACT ON HEALTH INSURANCE INDUSTRY

While the necessary funding has not been properly secured for the risk corridor program, it would be an unwise decision for Congress to revoke the program at this point in the implementation of the ACA.⁵¹ Revocation of the risk corridor program would raise questions of the trustworthiness of the federal government, put private insurers at much higher risk, and increase dramatically the cost to the federal government.⁵²

The federal government has entered into contracts with private insurers promising the safety net of the risk corridor program.⁵³ The private insurers have relied on these governmental promises in setting their premiums and if not honored the insurers could file suit against the federal government under the Fifth Amendment.⁵⁴ In not honoring the contract with private insurers, the government puts the insurers at tremendous risk and could possibly face liability due to its actions.⁵⁵

The risk corridor program is an essential part of the ACA's success and an essential part of making health insurance affordable for all citizens, whether wealthy or poor.⁵⁶ Therefore, the risk corridor program should not

50. Timothy Jost, Health Affairs Blog, Updates: Risk Corridor Payments (Sept. 30, 2014) ("CMS is currently operating under a continuing resolution and does not yet have an FY 2015 appropriation") available at <http://healthaffairs.org/blog/2014/09/30/implementing-health-reform-judge-rules-against-premium-tax-credits-in-aca-federal-exchanges/>.

51. See AM. ACADEMY OF ACTUARIES, *supra* note 7 ("Any changes to these provisions should be made with careful consideration of these interrelationships and the impact of how revisions could affect insurer risks, insurance availability, and insurance premiums").

52. Jost, *supra* note 36, at 5 ("Removing the back-stop of the risk corridor program would put private insurers at much higher risk, possibly leading to insolvencies that would need to be covered at great expense by the state and federal governments. It would certainly lead to fewer insurers participating in the exchanges in 2015, and to higher premiums.").

53. Jost, *supra* note 50 ("the failure of the United States to honor its commitment to private insurers under the risk corridor program could be an unconstitutional taking, prohibited by the Fifth Amendment, as contractual rights are property rights for purposes of the Fifth Amendment.").

54. *Id.*

55. *Id.*

56. John Tozzi, *Obamacare's 'Bailout' Could Earn Billions for the Government*,

be revoked due to its importance to the health care system in the United States and Congress should provide the proper constitutional funding. This would entail Congress passing a specific appropriation for the risk corridor program in 2015, the year that collections and payments are to be made by the Secretary of HHS to private insurance companies.

VI. CONCLUSION

The funding for the ACA risk corridor program is unconstitutional because Congress has not provided a specific appropriation for the funding of the program either through direct appropriation or delegation of the ability to run a revolving fund to HHS. Although the funding for this program is unconstitutional, it should not be revoked. Revocation of the risk corridor program would be tremendously detrimental to the implementation of the ACA and incredibly disastrous for low and middle-income citizens attempting to obtain insurance coverage. Therefore, Congress should vote to provide the proper funding for the risk corridor program through an appropriation in 2015. This would provide the constitutional authority for a program that is vitally important for the creation of a new healthcare system in the United States.

Bloomberg Businessweek (February 4, 2014) <http://www.businessweek.com/articles/2014-02-04/obamacares-bailout-could-earn-billions-for-the-government> (“It encourages them to offer plans in the exchanges, knowing that their losses will be limited if the people they enroll turn out to be much costlier—i.e., sicker—than anticipated. And it removes insurers’ incentives to recruit only the healthiest people.”).

Narrow Networks: The Need for Enhanced
Guidelines and Transparency

*Heather Lang**

I. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act, or ACA) provides for establishing Health Benefit Exchanges that offer health plans to individuals and employers.¹ These exchanges, now called “marketplaces,” are available in every state, either through a state or federally operated marketplace.² Health insurance marketplaces offer five categories of plans: Bronze, Silver, Gold, Platinum, and Catastrophic.³ While marketplace plans must have “adequate provider networks” in place, in practice this term is open to varying interpretations.⁴

Current research indicates that while most marketplace consumers are satisfied with their coverage, some have responded negatively to their new plans limiting their access to a relatively small number of providers, including hospitals and doctors.⁵ This limitation is referred to as a “narrow net-

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1. Patient Protection and Affordable Care Act of 2010, 42 U.S.C.A. § 18031 (West, WestlawNext through Pub. L. No. 113-145 (excluding Pub. L. No. 113-121, 113-128, 113-143) approved Aug. 4, 2014).

2. *Id.* §1321 of the ACA provides that if a State does not elect to operate its own exchange, or has not taken steps necessary to implement its exchange, the Secretary of the Department of Health and Human Services shall establish and operate the exchange within the state. *Id.* § 18041 (West, WestlawNext through Pub. L. No 113-163 (excluding Pub. L. No. 113-128) approved Aug. 8, 2014).

3. U.S. Ctrs. for Medicare & Medicaid Servs., *How to Choose Marketplace Insurance: Comparing Health Plans*, HEALTHCARE.GOV, <https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/> (last visited Sept. 29, 2014).

4. Carolyn Long Engelhard, *Pick Your Poison: Cost vs. Choice in ACA Marketplace Insurance Plans*, THE HILL (July 16, 2014, 6:30 AM), <http://thehill.com/blogs/pundits-blog/healthcare/212344-pick-your-poison-cost-vs-choice-in-aca-marketplace-insurance>.

5. *Id.*

work.”⁶ While the ACA does not mandate narrow networks, it does promote competition among insurers.⁷ Faced with more limited cost-control options, insurers turned to narrow networks as a competitive solution.⁸ To compete on price, insurance companies will control the costs of their customers’ care by contracting selectively with doctors and hospitals that charge less.⁹

Despite their potential for cost-containment, narrow networks may leave consumers disappointed when they are no longer able to see their regular doctor or when newly insured individuals face limited choices.¹⁰ In 2009, almost a year before he signed the ACA into law, President Obama addressed the American Medical Association.¹¹ In his speech, the President promised, “If you like your doctor, you will be able to keep your doctor, period.”¹² After the ACA was passed and implementation began, consumers began to learn that this promise was a qualified one. In response to regulations guiding insurers, many insurers made changes to their plan benefits, meaning that the plan was no longer “grandfathered.”¹³ As consumers were moved to new plans, they were not, in fact, always able to keep their doctors.¹⁴ Unfortunately, barely a quarter of marketplace customers knew the scope of the network they were enrolling in when they signed up for cover-

6. *Id.*

7. David Blumenthal, *Reflecting on Health Reform—Narrow Networks: Boon or Bane?*, THE COMMONWEALTH FUND BLOG (Feb. 24, 2014), <http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane>.

8. *Id.*

9. *Id.*

10. See Long Engelhard, *supra* note 4 (discussing narrow networks as one of the least expensive and limited plans in the marketplace).

11. Masuma Ahuja, *Timeline: Obama’s Promise That People Can Keep Their Insurance*, THE WASH. POST (Oct. 31, 2013), <http://www.washingtonpost.com/blogs/post-politics/wp/2013/10/31/timeline-obamas-promise-that-people-can-keep-their-insurance/>.

12. *Id.*

13. Glenn Kessler, *Obama’s Pledge That ‘No One Will Take Away’ Your Health Plan*, THE WASH. POST (Oct. 30, 2013), <http://www.washingtonpost.com/blogs/fact-checker/wp/2013/10/30/obamas-pledge-that-no-one-will-take-away-your-health-plan/>.

14. See Ahuja, *supra* note 11.

age.¹⁵ This sparked debate as to whether a connection exists between the cost of health care and the quality of a provider,¹⁶ resulting in actions such as lawsuits brought over adequate coverage¹⁷ and state actions.¹⁸

This article begins by reviewing the ACA and related requirements for health plans participating in the marketplace, including requirements for their provider networks, before exploring the ACA's role in the return of the narrow provider network. This article then explores the resulting state and federal response to the narrow network backlash and ultimately concludes that although the ACA calls for increased transparency from insurers, network scope remains opaque for many consumers. Until insurance companies provide greater transparency on their networks, consumer satisfaction will suffer and litigation and regulatory involvement will continue.

II. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

President Obama signed the Affordable Care Act into law on March 23, 2010.¹⁹ A sweeping and interdependent legislative pastiche, the ACA created various health insurance reforms that would “roll out” over a minimum

15. See Kessler, *supra* note 13 (reporting that many people were receiving notices that their old plan was cancelled because it did not meet the expected requirements).

16. Sarah Kliff, *Obamacare's Narrow Networks Are Going to Make People Furious—But They Might Control Costs*, THE WASH. POST WONKBLOG (Jan. 13, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/13/obamacares-narrow-networks-are-going-to-make-people-furious-but-they-might-control-costs/>.

17. See Demand for Jury Trial at 2, N.Y. State Psychiatric Ass'n, Inc. v. UnitedHealth Grp., No. 1:13CV01599, 2013 WL 870320 (S.D.N.Y. 2004) (alleging United's implementation of unlawful and deceptive practices and resulting undermining of access to treatment).

18. See Jay Hancock, *'Narrow Networks' Trigger Push-Back from State Officials*, KAISER HEALTH NEWS (Nov. 25, 2013), <http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx> (discussing actions taken by Maine, Washington, New Hampshire, South Dakota, Pennsylvania, and Mississippi).

19. Patient Protection and Affordable Care Act of 2010, 42 U.S.C.A. § 18031 (West, WestlawNext through Pub. L. No. 113-145 (excluding Pub. L. No. 113-121, 113-128, 113-143) approved Aug. 4, 2014). Just one week later, the Health Care and Education Reconciliation Act was enacted to amend and revise the ACA. See Pub. L. No. 111-152, 124 Stat. 1029-124 (2010). For a discussion on the “ad hoc” legislative history of the ACA, see John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131, 131 (2013) (discussing how the ACA is not a single bill but two, and how its legislative process illustrates a new legislative model).

four-year period.²⁰ Key features of the legislation included consumer protections, access to insurance for uninsured Americans with pre-existing conditions, and the creation of a health insurance marketplace.²¹ Originally dubbed “Health Benefit Exchanges” in the ACA,²² marketplaces exist in every state, either through a state or federally operated marketplace.²³

III. PLAN REQUIREMENTS AND THE MEANING OF “ADEQUATE”

The ACA requires that insurers cover a set of ten essential health benefit (EHB) categories, which they must offer within the actuarial value²⁴ limits of the various plan levels.²⁵ In addition, federal regulation requires that insurers provide an adequate provider network to their consumers.²⁶ The Centers for Medicare & Medicaid Services’ (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) stated that network adequacy standards are designed to provide a “basic level of consumer protection”

20. U.S. Dep’t of Health & Human Servs., *Key Features of the Affordable Care Act by Year*, HHS.GOV/HEALTHCARE, <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html> (last visited Sept. 29, 2014).

21. *Id.*; see also Sara Rosenbaum, *The QHP Certification Process in Federally-Facilitated Exchanges: Network Adequacy and Essential Community Providers*, HEALTHREFORMGPS (Mar. 27, 2013), <http://www.healthreformgps.org/resources/the-qhp-certification-process-in-federally-facilitated-exchanges-network-adequacy-and-essential-community-providers/> (describing the ACA’s insurance reforms, including, but not limited to, a bar on annual and lifetime limits on coverage; a ban on unjustified rescissions and on discriminatory premiums that address variables other than age, use of tobacco, family status and geographic rating area; coverage for young adults up to age 26; and appeals procedures).

22. 42 U.S.C.A. § 18031.

23. *Id.*

24. See 45 C.F.R. § 156.135 (2014) (describing the actuarial value calculation for determining the level of coverage).

25. 42 U.S.C.A. § 18022; David Cusano & Amy Thomas, *Narrow Networks Under The ACA: Financial Drivers and Implementation Strategies*, HEALTHAFFAIRS BLOG (Feb. 17, 2014), <http://healthaffairs.org/blog/2014/02/17/narrow-networks-under-the-aca-financial-drivers-and-implementation-strategies/>; U.S. Ctrs. for Medicare & Medicaid Servs., *Essential Health Benefits*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Oct. 1, 2014). EHB include items and services for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. *Id.*

26. See 45 C.F.R. § 156.230 (setting forth the network adequacy standards).

while still allowing Qualified Health Plan (QHP) issuers to compete for business.²⁷ CMS emphasized its intent to avoid duplicating a state review and acknowledged that if network adequacy is part of a state's issuer license review, the federal process will rely on state review and recommendations.²⁸ In an effort to leave states as much flexibility as possible, the U.S. Department of Health and Human Services (HHS) only incrementally provided guidance on what constitutes an adequate network.²⁹

When first proposing regulations that would establish the marketplace, HHS described an adequate network as one that provides a "sufficient choice of providers."³⁰ Current regulations go further, requiring that QHPs include essential community providers³¹ in their network and "maintain- a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."³² In addition, regulations also require a QHP issuer make its QHP provider directory available to the exchange for online publication and to potential enrollees in hard copy upon request.³³

IV. THE RETURN OF THE NARROW PROVIDER NETWORK

Implementation of the health insurance marketplace in 2014 left many

27. Ctr. for Consumer Info. & Ins. Oversight, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F): Regulatory Impact Analysis*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1 (Mar. 2012), <https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf>.

28. Rosenbaum, *supra* note 21.

29. Timothy Jost, *Implementing Health Reform: A Final Rule on Health Insurance Exchanges*, HEALTHAFFAIRS BLOG (Mar. 13, 2012), <http://healthaffairs.org/blog/2012/03/13/implementing-health-reform-a-final-rule-on-health-insurance-exchanges/>.

30. Patient Protection and Affordable Care Act, 77 Fed. Reg. 18310, 18418 (Mar. 27, 2012) (to be codified at 45 C.F.R. pt. 155, 156, 157).

31. See 45 C.F.R. § 156.235 (providing that Essential Community Providers are those that serve predominantly low-income, medically underserved individuals).

32. *Id.* § 156.230.

33. *Id.*

consumers happy with their coverage, but left others angry that their new plans limited their access to a relatively smaller number of providers.³⁴ This limitation is referred to as a “narrow network.”³⁵ Narrow networks are health insurance plans that limit the providers that are available to subscribers.³⁶ An insurer can create a narrow network with two approaches: (1) by not paying at all if a subscriber visits a doctor outside of the narrow network; or (2) by charging a higher co-pay to see an out-of-network doctor.³⁷

Narrow networks are nothing new. They are, in fact, something of a retrospective, first emerging in the early 1990s when managed care organizations employed them to control spending.³⁸ Although they proved unpopular and insurers moved back to broader networks,³⁹ they have returned with employer-based health insurance.⁴⁰ As employers strived to control health insurance costs, narrow network plans expanded from fifteen percent of employer insurance plans to twenty-three percent of plans between 2007 and 2012.⁴¹ Narrow network employer plans provided cost savings between ten percent and twenty-five percent.⁴² This, presumably, is in exchange for networks that are anywhere from fifteen percent to thirty-five percent smaller than standard preferred provider panels.⁴³

While the ACA does not mandate narrow networks, it does incentivize these networks to compete for business while it simultaneously controls the ways in which they can do so.⁴⁴ Insurance companies seeking to control the

34. Long Engelhard, *supra* note 4.

35. *Id.*

36. Kliff, *supra* note 16.

37. *Id.*

38. Long Engelhard, *supra* note 4.

39. *Id.*

40. Kliff, *supra* note 16.

41. *Id.*

42. M.P. McQueen, *Less Choice, Lower Premiums: Many Exchange Plans Will Offer Narrow Networks*, MODERN HEALTHCARE (Aug. 17, 2013, 12:01 AM), <http://www.modernhealthcare.com/article/20130817/MAGAZINE/308179921>.

43. *Id.*

44. Blumenthal, *supra* note 7.

costs of their customers' care may do so by contracting selectively with doctors and hospitals that charge less.⁴⁵ Not only do narrow networks provide a competitive edge, they also give insurers more leverage—as they buy services in bulk from preferred providers, they are able to negotiate better prices for the future.⁴⁶

Although narrow networks may allow insurers to contain costs and remain competitive, they are not always well received by consumers. In fact, they may prove frustrating to consumers who find that the network excludes their regular or preferred doctors.⁴⁷ For some patients with several health problems, a narrow network might mean difficulty accessing a particular specialist.⁴⁸ Critics also argue that although insurers may not discriminate against people with pre-existing conditions, they may “subtly discourage” sicker patients from enrolling by limiting the provider network.⁴⁹ Mark E. Rust, chairman of Barnes & Thornburg's national health care practice, explains: “If a health plan has a narrow network that excludes many doctors, that may shoo away patients with expensive pre-existing conditions who have established relationships with doctors.”⁵⁰

The effect of the narrow network may also be felt disproportionately on those with the greatest need for insurance coverage. Since cost is often the greatest factor when a consumer chooses a health plan, those consumers who purchased products via the marketplace often opted for less expensive plans with narrow networks.⁵¹ A recent study revealed that while nearly half of the networks on the insurance marketplace had limited networks, nearly

45. *Id.*

46. Kliff, *supra* note 16.

47. Long Engelhard, *supra* note 4.

48. *Id.*

49. Robert Pear, *Lower Health Insurance Premiums to Come at Cost of Fewer Choices*, N.Y. TIMES (Sept. 22, 2013), http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html?pagewanted=all&_r=1&.

50. *Id.*

51. Long Engelhard, *supra* note 4.

seventy percent of the least-expensive plans had very restricted networks.⁵²

Although insurance companies and some researchers suggest that there is little connection between the cost of health care and the quality of a provider,⁵³ many consumers and states disagree. In 2013, before the federal marketplaces went into effect, a New York resident brought suit against United Healthcare for failure to provide adequate mental health coverage.⁵⁴ More recently, thirty-three Anthem subscribers in California sued the insurer, accusing it of misrepresenting the size of its networks.⁵⁵ In some cases, the consumers claim Anthem canceled their plans with broader networks, forcing them to incur large, unforeseen medical bills when they visited out of network providers.⁵⁶

As America debates the value of narrow networks, researchers are finding consumers under-informed with respect to their selected plan's network: disturbingly, only twenty-six percent of marketplace customers knew the scope of the network when they enrolled.⁵⁷ With so few informed selections in the marketplace's first year, advocacy groups are calling for increased payer transparency to enable consumers to make better decisions.⁵⁸

52. Noah Bauman et al., *Hospital Networks: Updated National View of Configurations on the Exchanges*, MCKINSEY ON HEALTHCARE (June 2014), <http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges>.

53. Kliff, *supra* note 16; see also Margot Sanger-Katz, *Narrow Health Networks: Maybe They're Not So Bad*, N.Y. TIMES (Sept. 9, 2014), http://www.nytimes.com/2014/09/10/upshot/narrow-health-networks-maybe-theyre-not-so-bad.html?_r=0 (highlighting a study published as a working paper with the National Bureau of Economic Research which followed Massachusetts state workers who selected a narrow network plan, and found that when done correctly, a narrow network can be successful in both saving money and providing patients with appropriate health care).

54. See Demand for Jury Trial, *supra* note 17, at 2.

55. Chad Terhune, *Anthem Blue Cross Sued Again over Narrow-Network Health Plans*, L.A. TIMES (Aug. 19, 2014, 6:38 PM), <http://www.latimes.com/business/la-fi-anthem-network-suit-20140820-story.html>.

56. *Id.*; Julia Appleby, *Lawsuit Accuses Anthem Blue Cross of 'Fraudulent' Enrollment Practices*, KAISER HEALTH NEWS (July 9, 2014), <http://www.kaiserhealthnews.org/stories/2014/july/09/anthem-lawsuit-over-enrollment-practices.aspx>.

57. Bauman et al., *supra* note 52.

58. Keith Griffin, *Narrow Networks: Obamacare's Broken Promise and How Doctors and Patients Can Fight Back*, MEDICAL ECONOMICS (Mar. 24, 2014), <http://medical.economics.modernmedicine.com/medical-economics/news/narrow-networks-obamacares->

V. STATE AND FEDERAL RESPONSE

Advocacy groups are not alone in calling for further refinements to insurance reform. Many states are taking action in response to the perceived threat that narrow networks provide.⁵⁹ Maine regulators stopped Anthem BlueCross BlueShield from switching customers to a marketplace plan that excluded six hospitals in the state.⁶⁰ New Hampshire lawmakers authored legislation forcing insurers to expand provider networks after 2014 marketplace plans excluded more than one third of the state's hospitals.⁶¹ The Washington State Insurance Commissioner initially blocked several health plans from the online exchange due to "inadequate caregiver networks" and recently took action after discovering one plan would have patients drive more than one hundred miles just to see a gastroenterologist.⁶² In South Dakota, Pennsylvania, and Mississippi, legislators are contemplating "any-willing provider" laws that would require insurers to accept more providers in their networks.⁶³ In September 2014, California Governor Jerry Brown signed legislation that increases scrutiny of provider networks.⁶⁴ These state actions often result in appeals, further litigation, state legislative action, and/or additional lawsuits.⁶⁵

In addition to the robust state response, the National Association of Insurance Commissioners is revising its model regulations for network ade-

broken-promise-and-how-doctors-and-patients-can-fi?page=full.

59. See Hancock *supra* note 18.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*; Paul Demko, *Reform Update: Narrow-Network Concerns Spur Legal, Regulatory, Political Action*, MODERN HEALTHCARE (Sept. 26, 2014, 4:00 PM), <http://www.modernhealthcare.com/article/20140926/NEWS/309269967> (discussing South Dakota's pending "any willing provider" legislation, which predates Marketplace implementation, and acknowledging that 2014 was a "tricky" year for legislatures, as many were far into their sessions or had adjourned before constituents began using marketplace health plans and discovered problems with narrow networks). With 2014's experience behind them, many legislatures may start with increased attention on this topic in 2015. *Id.*

64. Demko, *supra* note 63.

65. See Hancock *supra* note 18 (noting also that tensions over narrow provider networks have been especially high in California).

quacy, with a new draft policy anticipated in late 2015.⁶⁶ The federal government also proposed guidelines that will allow CMS and HHS to scrutinize plan networks.⁶⁷ In a final letter dated March 14, 2014, CCIIO notified issuers in the Federally-facilitated marketplaces that in the 2015 benefit year, CMS will assess provider networks using a “reasonable access” standard.⁶⁸ In evaluating whether a network meets this standard, CMS will assess those areas that have “historically raised network adequacy concerns,” including hospital systems, mental health providers, oncology providers, and primary care providers.⁶⁹

VI. CONCLUSION

Although the ACA calls for increased transparency from insurers, network scope remains opaque for many consumers. Until insurance companies provide greater transparency on their networks, consumer satisfaction will suffer, and litigation and regulatory involvement will continue. Fortunately, there are signs that network transparency will improve in the near future.

Recent federal guidelines on network adequacy, as well as regulations requiring issuers to provide network information to the marketplace, provide opportunity not only for adequate networks, but for more informed consumer choice. That choice may be aided by one or more transparency tools, including requiring announcements online and on printed materials that alert potential enrollees the network is limited and urge them to review

66. Demko, *supra* note 63.

67. Alison Ritchie, *Obama Administration Sets Physician Network Standards for 2015 Federal Exchange Plans*, MEDICAL ECONOMICS (Mar. 18, 2014), <http://medical.economics.modernmedicine.com/medical-economics/news/obama-administration-sets-physician-network-standards-2015-federal-exchange-p>.

68. Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs. to Issuers in the Federally-facilitated Marketplaces (Mar. 14, 2014), *available at* <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

69. *Id.*

the provider directory before choosing a policy.⁷⁰ Alternatively, issuers could achieve greater transparency by posting online a map showing the location of each provider in a network.⁷¹ Whatever the mechanism, enhanced network transparency will increase the likelihood that those who choose a narrow network are picking the right plan for their circumstances.

70. Sally McCarty, *Helping States Address Transparency of Health Plan Provider Networks*, GEO. U. HEALTH POL'Y INST.: THE CTR. ON HEALTH INSURANCE REFORMS (Oct. 10, 2014), <http://chirblog.org/helping-states-address-transparency-of-health-plan-provider-networks/>.

71. *Id.*

Repeal of the McCarran Ferguson Act: A Means to
an End?

*Markeya Fowler**

I. INTRODUCTION

How can we contain health care costs without negatively affecting quality? This is the question that lawmakers continue to struggle with and so far remains unanswered. The healthcare system requires reform but the best method of achieving this reform is uncertain. The Patient Protection and Affordable Care Act (ACA) was the first wave of legislation that resulted in the merging of healthcare entities in an effort to increase collaboration and accountability for patient care among providers. The ACA targeted the healthcare system as a whole, but there are efforts to reform health care by targeting specific areas of the market.

The Health Insurance Industry Antitrust Enforcement Act (the Act) was designed to reform access to health care by increasing competition in the health insurance market.¹ Specifically, the Act is an amendment to the McCarran Ferguson Act (MFA) proposing elimination of exemption from Federal Antitrust law provided to health insurers.² Beginning in 2007,³ Congress has introduced several bills attempting repeal of the MFA but has not gained consensus among the parties to pass any into law, the Act is the newest bill attempting repeal.⁴ The first proposals were not able to gain

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1. See H.R. 99, 113th Cong. (2013).

2. *Id.* (“Nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance”).

3. *Id.*

4. Carl W. Hittinger & John D. Huh, *Health Insurance Antitrust Exemption Temporari-*

enough votes to pass, and later versions of the Act were removed in negotiations for passage of the ACA.⁵ However, there is still support for the passage of the Act repealing the MFA exemption by Congress, including the support of President Barack Obama.⁶ House Democrats claim repeal of the MFA is the most effective way to prohibit collusion among health insurance companies and effectively contain growing health care costs.^{7,8}

This article will focus on the MFA and explain why its implementation is a necessary step towards providing low cost, quality health care by analyzing its purpose, the solution it provides, and the predicted outcome. Section II will provide background information on the exemption under the MFA and why it was implemented. Section III will analyze the MFA and explain why repeal is necessary. Finally, section IV will analyze the expected impact of the MFA repeal and whether it will have any substantial effect on the health insurance industry. The MFA should be repealed in order to effectively reform the health insurance industry and provide quality, low cost health care to consumers by introducing competition and diversity into the insurance market.

II. BACKGROUND

The MFA was passed in 1948 in response to the Supreme Court decision in *United States v. South-Eastern Underwriters Association*, ruling that the business of insurance fell into interstate commerce and was subject to fed-

ly Escapes Repeal, LEGAL INTELLIGENCER (Apr. 5, 2010) (discussing a bill introduced in 2010). Jessica Dye, *Experts Wary of Health Insurance Antitrust Bill*, LAW 360 (Oct. 8, 2009) (discussing a bill introduced in 2009), <http://www.law360.com/articles/126202/experts-wary-of-health-insurance-antitrust-bill>.

5. *Hittinger & Huh*, *supra* note 4.

6. *Pelosi Wants Reform Bill To Tackle Insurers' Antitrust Exemption*, INSIDE HEALTH REFORM (Oct. 22, 2009) [hereinafter *Pelosi Wants Reform*].

7. Same Baker, *House Dems Target Insurers' Antitrust Exemption*, THE HILL (Feb. 19, 2013), <http://thehill.com/policy/healthcare/283823-house-dems-target-insurers-antitrust-exemption>.

8. *Pelosi Wants Reform*, *supra* note 6.

eral regulation.⁹ The MFA allows health insurers to escape judicial scrutiny under federal antitrust laws, specifically the Sherman and Clayton Acts.¹⁰ The MFA states that no act of Congress shall supersede any law enacted by any state for the purpose of regulating the business of insurance, and that every person therein is subject to state laws relating to the regulation or taxation of insurance.¹¹

The Sherman Act, passed in 1890, prohibits contracts restraining trade and any actions resulting in monopolization, or conspiracy to monopolize.¹² The Clayton Act, passed in 1914, served to strengthen the Sherman Act and prohibits specific acts having anti-competitive effects.¹³ That same year, the Federal Trade Commission Act (FTC Act) was passed which broadly encompasses the Sherman and Clayton Acts.¹⁴ Under the FTC Act, parties may bring trade restraint and monopolization cases under the Sherman Act, as well as claims for other activities not formally prohibited by the Sherman Act that have harmed competition, such as unfair or deceptive advertising and consumer fraud.¹⁵

Before *United States v. South-Eastern Underwriters Association*, the insurance industry was regulated under state law and not considered interstate commerce by the Supreme Court.¹⁶ This case marks the Supreme Court's change of opinion and has caused concern among various states, specifically regarding how state legislation and taxation will be effected by federal regulation and whether federal law would supersede state law.¹⁷ In response

9. See *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 553 (1944).

10. *Id.*

11. McCarran Ferguson Act, 15 U.S.C.A. § 1012.

12. SARALISA C. BRAU, DAVID MARX JR. & CHRISTINE L. WHITE, *ANTITRUST & HEALTHCARE: A COMPREHENSIVE GUIDE* 14 (1st ed. 2013).

13. *Id.* at 15.

14. *Id.* at 16-17.

15. *Id.*

16. Kimberly G. Tayner, *The Repeal of the McCarran-Ferguson Act & Competition in the Health Insurance Industry* 5 (May 2010) (unpublished thesis) (on file with the Loyola University Chicago School of Law Library).

17. *Id.*

to state concerns Congress passed the MFA allowing state laws regulating the business of insurance to supersede federal law.¹⁸ In order for this exemption to apply, the health insurers practices must constitute the business of insurance, be regulated by state law, and must not amount to a boycott, coercion, or intimidation.¹⁹ Practices are considered to be the business of insurance if they have the effect of transferring or spreading risk, are an integral part of the policy relationship between the insurers and insured, and are limited to entities within the insurance industry.²⁰ The exemption was designed to protect activities that help cope with risk in the industry.²¹ However, the exemption does not extend to the “business of insurance companies” such as the purchasing of goods, services, or products that do not relate to the spreading of risk.²²

As mentioned above, the MFA was passed in response to a sudden change in the Supreme Court’s position.²³ The McCarran Ferguson exemption maintained state regulations that were in place before the *United States v. South-Eastern Underwriters Association* decision and prevented uncertainty as to what extent federal regulations would apply.²⁴ Sixty-six years later, the exemption is broadly interpreted by the judiciary and allows health insurers to merge without implicating federal antitrust laws, which resulted in concentrated markets dominated by large insurance companies.²⁵ Many of these large companies are labeled as a monopsony or oligopsony,

18. McCarran Ferguson Act, 15 U.S.C.A. § 1012 (West 2014).

19. BRAU ET AL., *supra* note 12, at 539.

20. Chris Sagers, *Much Ado About Possibly Pretty Little: McCarran-Ferguson Repeal in the Health Care Reform Effort*, 28 YALE L. & POL’Y REV. 325, 334 (2010).

21. *Id.*

22. *Id.*

23. See *Se. Underwriters Ass’n*, 322 U.S. at 553 (overturning a previous case holding that insurance did not affect interstate commerce).

24. Tayner, *supra* note 16, at 5-6.

25. *Health Industry Consolidation: Hearing before the H. Comm. on Ways & Means, Subcomm. On Health*, 112th Cong. 1 (Sept. 9, 2011) (statement of David Balto, Senior Fellow, Center for American Progress Action Fund), available at http://cdn.americanprogress.org/wpcontent/uploads/issues/2011/10/pdf/balto_testimony.pdf [hereinafter *Hearing on Health Industry Consolidation*].

which dominate the market and negatively impact competition.²⁶ An oligopsony exists where there is a small group of insurers with a high concentration of power spread among the several insurers.²⁷ While repealing the MFA and subjecting health insurers to federal antitrust laws cannot change the concentration of the current market, it can help by subjecting future practices to scrutiny to help foster competition and reform in health care.²⁸ Judicial interpretation of the MFA exempts health insurance practices such as most favored nation agreements that limit competition when used by large health insurers.

III. REASONS FOR REPEAL OF THE MCCARRAN FERGUSON ACT

A. *Lack of State Regulation over Health Insurance Companies*

The MFA should be repealed because there is limited enforcement of health insurance regulation on the state level despite state legislative efforts. Regulation in states occurs in multiple ways, including licensing procedures, audits, the processes used to determine how networks are maintained and formed, and how prices are set.²⁹ States also have laws to regulate anti-competitive effects among health insurance companies.³⁰ However, very few states actually bring actions against health insurance companies to address practices that may be anti-competitive.³¹ Enforcement has been spo-

26. P.E. Hilsenrath & M. Destigter, *Oligoposony, health insurance and antitrust*, 43 MED. GRP. MGMT. J. 52, 53 (1996).

27. FED. TRADE COMM'N & DEP'T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* (2004), available at http://www.justice.gov/atr/public/health_care/204694/chapter6.htm.

28. BRAU ET AL., *supra* note 12, at 15 (explaining that antitrust legislation does not work retroactively and cannot undo monopolies already formed).

29. Michael G. Cowie, *Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action*, ANTITRUST SOURCE 7-8 (Dec. 2009), available at http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/Dec09_Cowie12_17f.authcheckdam.pdf.

30. *Id.*

31. David Balto & Stephanie Gross, *Unlocking Competition, The Need to Eliminate the Antitrust Exemption for Health Insurers*, CTR. FOR AM. PROGRESS 2 (Oct. 28, 2009) available at http://cdn.americanprogress.org/wp-content/uploads/issues/2009/10/pdf/unlocking_competition.pdf.

radic with few consumer protection actions and no actions against anti-competitive conduct.³² Even in those states where the concentration of the market is at its highest, no actions against health insurers occurred in the past five years.³³ The MFA requires states to have regulations in place for the exemption to apply, but it does not mandate that states actually take action on the laws that it has in place.³⁴ Federal case law suggests that, as long as there is a state law in place, the exemption stands even if it is ineffective.³⁵ A state law that only minimally regulates and touches on the issue of antitrust is sufficient to preserve the exemption under the MFA.³⁶ This system of enforcement allows insurers to escape scrutiny on the federal level for practices that may negatively affect competition and escape scrutiny on the state level as a result of such relaxed enforcement.³⁷ Repeal of the MFA solves this problem by eliminating the exemption allowing health insurer practices to escape federal antitrust legislation as long as the practice is regulated under state law.

The McCarran Ferguson exemption should be repealed to implement uniform application of antitrust regulations instead of permitting the degree of restriction to vary from state to state.³⁸ For instance, an insurer in one state may be able to escape antitrust scrutiny in one state, but not in another because there are no guidelines on how stringent state laws must be for the exemption to apply.³⁹ This presents an advantage for insurers that are large enough to operate across multiple states and can control a relevant market

32. *Id.*

33. *Id.*

34. BRAU ET AL., *supra* note 12, at 539.

35. Balto & Gross, *supra* note 31, at 3.

36. *Id.*

37. *Id.* (Insurers are exempt from federal law because they are regulated under state law, but there have been limited enforcements in past five years).

38. Tayner, *supra* note 16, at 26 (explaining that state law only extends to the borders of the regulating state, so if an insurer also acts in a non-regulating state, the activities in the non-regulating state are subject to federal antitrust authority).

39. *Id.*

based on how strict the state laws are imposed, if they are imposed at all.⁴⁰ An example of this scenario is the health insurance company Blue Cross Blue Shield, which provides coverage for almost fifty percent of the population in many states.⁴¹ Requiring a uniform application of federal antitrust laws may eliminate the varying degree of enforcement under state law and subject all health insurers to the same standard of legislation.

B. Slowing Further Consolidation of Insurance Markets

Repeal of the MFA can help slow consolidation in the health insurance industry and allow for more companies to enter the market.⁴² The concentration levels of health insurance markets exceed the threshold amount of the 2,500 points triggering antitrust liability.⁴³ Ninety-six percent of state health insurance markets are considered highly concentrated.⁴⁴ The trend shows that the market will continue to become more concentrated.⁴⁵ In fact, four hundred mergers occurred from 1996 to 2010.⁴⁶ A 2011 report lists thirty-nine states where two companies control at least fifty percent of the market and demonstrates that in nine states, a single company controls at least seventy-five percent.⁴⁷ Repeal of the MFA would increase judicial scrutiny of all future market consolidation that unreasonably restrains competition or allows achievement of market monopolization through insurance company mergers and acquisitions.⁴⁸ The application of federal antitrust

40. Hilsenrath & Destigter, *supra* note 26 (discussing Blue Cross Blue Shield as an example of an oligopsony, who in aggregate are large providers of insurance and cover significant percentages of patients in a given area).

41. *Id.*

42. Balto & Gross, *supra* note 31, at 1 (“A tsunami of health insurance mergers has led to high levels of concentration in practically every market to the point where there are only one or two dominant insurers in many states. New companies face substantial entry barriers, and so the local monopolies go unchallenged”).

43. Sagers, *supra* note 20, at 338.

44. *Id.*

45. *Id.*

46. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4.

47. *Id.*

48. BRAU ET AL., *supra* note 12, at 14.

law to all insurance companies can help slow market consolidation.⁴⁹ This oversight may hinder the ability of large insurers to dominate large portions of the market, removing access barriers for smaller insurance companies and likely resulting in a more diversified insurance marketplace.⁵⁰

The high concentration of health insurance companies within the market also effectively limits competition by preventing other companies from entering.⁵¹ For example, if an insurer wants to enter the Dallas, Texas market as an HMO or HMO-POS, it must dedicate two to three years and costs up to \$50 million due to the high concentration of the market.⁵² In St. Louis, Missouri, the HMO market is very concentrated and there has been no new insurer entry since the mid-1990s.⁵³ One of the causes of market domination by a single insurer is that larger companies typically negotiate more effectively with providers and grant consumers prices they believe to be reasonable.⁵⁴ In turn, consumers have little incentive to switch to other insurers that may have similar, or more likely, higher prices.⁵⁵ Subjecting health insurers to federal antitrust laws, slowing consolidation, and introducing competition provides consumers with more choices among companies and requires insurers to provide the best deal for the consumer by offering a better quality product at a lower price.

49. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4 (Concerns over healthcare consolidation should focus on the need to prevent increases in concentration by health insurers. Insufficient focus on this area in the past has given way to a very poorly functioning health insurance market. Few markets are as concentrated, opaque, and conducive to deceptive and anticompetitive conduct).

50. *Id.*

51. Balto & Gross, *supra* note 31, at 1 (explaining that new companies face substantial entry barrier, and so these local monopolies go unchallenged).

52. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 27, at 6.

53. *Id.* at 7.

54. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4 (discussing how advocates believe markets have several competitors, but in reality the small players are not a competitive restraint on dominant firm and just follow the larger firms' price increases).

55. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4.

IV. EXPECTED IMPACT OF THE REPEAL OF THE MFA EXEMPTION

A. *Effect on Competition in the Market*

Repeal of the MFA will have little impact unless the courts change how they view health insurers' price setting practices. The courts have granted health insurers great latitude when evaluating whether their practices are in violation of the Sherman Act.⁵⁶ For example, practices such as banning balance billing, most favored nation (MFN) clauses, and reimbursement caps were found not to harm competition in many cases.⁵⁷

One of the restrictions imposed by insurers is a ban on balancing billing which prohibits providers from billing the patient for any additional payments beyond what the insurer has set as the reimbursement amount for services rendered.⁵⁸ If the provider decides not to participate by refusing the health insurers' reimbursement as payment in full, the provider can be precluded from receiving any payments from the insurer and banned from treating patients of that insurer.⁵⁹ Another device used in the practice of insurance, the MFN clause, is a contractual agreement between insurer and provider that requires the provider to sell to the insurer on pricing terms that are at least as favorable as the pricing terms given to any other insurer.⁶⁰ This requires the provider to charge all insurers similar prices and offer similar discounts, regardless of the customer base.⁶¹ Finally, insurers often use reimbursement caps to limit the amount paid to a provider for services rendered.⁶² An insurer contracts with providers on this reimbursement amount, but if a provider outside of this contract renders services, they will receive a

56. Hilsenrath & Destigter, *supra* note 26, at 55.

57. *Id.* at 55-57.

58. *Id.*

59. *Id.*

60. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 27, at 13.

61. *Id.*

62. Hilsenrath & Destigter, *supra* note 26, at 57.

lower reimbursement compared to contracted providers.⁶³ This practice compels patients to see only contracted providers to insure that the services will be covered and there will be limited out-of-pocket expense.⁶⁴

The ban on balance billing works to keep prices low for consumers but stifles competition by preventing providers from charging different rates.⁶⁵ If the insurer has market power, the provider will accept the reimbursement amount offered by the insurer rather than lose access to the large percentage of patients covered by the insurer.⁶⁶

MFN clauses work to prevent providers from charging smaller insurers less because providers cannot sustain business if the largest amount of their patient population and source of revenue is being cared for at a low market rate.⁶⁷ Providers cannot terminate contracts with large insurers because of the large percentage of beneficiaries that they cover.⁶⁸ As a result, providers are forced to charge a blanket rate to all insurers and many small insurers may not be able to compete.⁶⁹

A ban on balance billing is a positive business strategy, but with the market power of large contracting insurers, anti-competitive effects are likely.⁷⁰ A ban on balance billing and MFN clauses alone are not anti-competitive, however, when combined with market power they can effectively limit competition by setting reimbursements at levels beneficial to the

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.* at 55 (discussing how those providers who do not agree to the insurers reimbursement rate are not allowed participatory status and may be precluded from receiving payment whatsoever from treating patients of the insurer).

67. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 27 (discussing that a MFN clause may harm competition either by substantially raising costs of the insurer's rivals or reducing provider discounting in the particular market).

68. BRAU ET AL., *supra* note 12, at 467.

69. *Id.*

70. *Id.* at 56 (discussing the unlimited rights of a buyer to set its own terms and bargain for the best price, and that discriminatory reimbursement constitutes hard bargaining rather than anticompetitive conduct).

insurer but not to the provider.⁷¹

Similarly, repeal of the McCarran Ferguson exemption will have little effect unless courts change how federal antitrust laws apply to health insurers' practices.⁷² In previous cases, many of the practices that harm competition have been found to be lawful under the Sherman Act.⁷³ This will not change with repeal of the exemption. However, these activities may fail if scrutinized under the FTC Act.⁷⁴ The FTC Act applies much more broadly and does not point to specific practices or activities that are illegal, allowing for general practices that restrain trade or harm competition to be challenged.⁷⁵ But interpretation of section six of the FTC Act suggests the FTC does not have authority to investigate health insurance without Congressional approval.⁷⁶ Section six states the FTC has the power to investigate persons and corporations whose business affects commerce but the power to investigate violations of antitrust statutes exists when commanded by the President or either House of Congress. Clarification of this limitation by Congress would allow the FTC to bring cases based on competition and consumer protection that were previously ruled unlawful under the Sherman Act.⁷⁷ Because many of the anti-competitive practices were previously ruled legal under the antitrust laws, repeal of the exemption without further action will change very little in the context of challenging insurers' practices.

B. Effect on Information Sharing in the Health Insurance Market

Information sharing among insurance companies will likely not be tar-

71. Hilsenrath & Destigter, *supra* note 26, at 55 (“[I]n these cases, rather than bargaining with providers for a contract price, the powerful payor may have the ability to unilaterally set reimbursement below market levels.”).

72. *Hearing on Health Industry Consolidation*, *supra* note 25, at 12 (The FTC should scrutinize anticompetitive conduct by health insurers and providers).

73. *Id.*

74. *Id.*

75. BRAU ET AL., *supra* note 12, at 16 (The FTC Act broadly declares unlawful unfair methods of competition in or affecting commerce).

76. *Hearing on Health Industry Consolidation*, *supra* note 25, at 12.

77. *Id.*

geted by repeal due to its pro-competitive effect and because it is subject to state regulation and therefore exempt under the MFA.⁷⁸ Health insurers expressed concern that sharing loss information will be scrutinized if the MFA is repealed, impeding the ability to predict costs.⁷⁹ Sharing loss information allows insurers to predict costs incurred in a given year before they actually realize the costs.⁸⁰ Loss information is used by actuaries and analyzed to set premiums at a rate that is attractive to consumers and protects the insurer from insolvency.⁸¹ Scrutinizing insurers' practice of sharing loss data under federal antitrust law is unlikely because the price sharing and historical loss information currently shared is not detailed enough to raise anti-competitive concerns.⁸² The legality of the aggregation and dissemination of this data rests largely on whether client-identifying information is present; if identifiers are removed, then this practice likely remains legal.⁸³

However, this may not have a negative effect on large insurance companies because even if this practice is subject to scrutiny under federal antitrust laws, these insurance giants have enough historical data to accurately predict their costs.⁸⁴ A ban on information sharing in the insurance marketplace will only affect small insurers attempting to enter the market due to their inability to gather loss information on a large scale.⁸⁵ Imposing a limit on information sharing will fail to achieve the desired result of increasing competition and instead will serve to stifle it by preventing smaller insurers from competing with the larger insurers in the market place.

78. Sagers, *supra* note 20, at 347.

79. Repeal of Antitrust Exemption Would Not Hurt Insurance Industry, 23 CORP. CRIME REP. 42(14) (Oct. 30, 2009), available at <http://corporatecrimereporter.com/stutz103009.htm>.

80. *Id.*

81. *Id.*

82. Sagers, *supra* note 20, at 348.

83. *Id.*

84. Jenny Gold, *The Antitrust Exemption For Health Insurers: Meaningful Or Not?*, KAISER HEALTH NEWS (Feb. 24, 2010), <http://www.kaiserhealthnews.org/stories/2010/february/05/antitrust-health-insurance.aspx>.

85. Hittinger & Huh, *supra* note 4.

V. CONCLUSION

Repeal of the MFA is a necessary step toward improving the healthcare system by exposing health insurers to uniform federal antitrust liability. Currently, differing legislation among the states results in a variation of enforcement and regulation across the country. Repeal would expose health insurers to a high level of judicial scrutiny when attempting to consolidate when there is a potential for negative impact on competition in a specific insurance market. Scrutinizing all transactions under the Sherman and Clayton Acts imposes the same level of federal regulation, decreasing the amount of transactions that have anti-competitive effects or restrain trade. This allows smaller insurers easier entry into the market and increases diversity.

While repeal cannot retroactively undo the high level of market concentration, it is the first step in reducing the barrier to market entry by diminishing the ability of large insurers to consolidate and control a majority of the population in a given area. Significantly, removing the McCarran Ferguson exemption will have minimal immediate impact without a further change in the way courts evaluate insurer practices and implement federal antitrust laws, but over time, repeal of the exemption could help to improve and reform the health insurance market.

The Affordable Care Act Compared to International
Health Care Systems: Can Changes in
Pharmaceutical Industry Impact the Health Care
System in the United States of America?

*Shaleen Dada**

I. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010 making the United States of America (U.S.) part of the vast majority of countries that provide affordable access to health care.¹ However, the U.S. is a fairly new player in the affordable healthcare market, as most European countries introduced similar programs as early as the 1800s.² The primary reason European countries implemented such programs so early on was to promote income stabilization and prevent wage loss of for the ill.³

In the early nineteenth century, American medicine was inefficient and controlled by for-profit organizations.⁴ Several institutions tried to change

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *See also*, Larry Bernstein, *Once again, U.S. has most expensive, least effective health care system in survey*, THE WASHINGTON POST, June 16, 2014, <http://www.washingtonpost.com/news/to-your-health/wp/2014/06/16/once-again-u-s-has-most-expensive-least-effective-health-care-system-in-survey/>.

2. Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM (1999), available at: <http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us>.

One of the first health care systems for sick workers began in Germany in 1883 with compulsory sickness insurance. Other countries including Austria, Hungary, Norway, Britain, Russia, and the Netherlands followed until 1912. Sweden in 1891, Denmark in 1892, France in 1910, and Switzerland in 1912, funded mutual benefit societies that workers created.

3. *Id.*

4. John M. Luce et al., *A Brief History of HealthCare Quality Assessment and Improvement in the United States*, 160 W. J. MED, 263, 263 (1994). available at:

this by establishing the Hospital Standardization Program in 1917.⁵ Since then, the U.S. has been pushing to improve health care but has faced resistance because of the socialist connotation that universal health care brings with it.⁶ Despite passing the ACA, the U.S. falls behind in quality health care compared to many industrialized countries.⁷ This article will compare the American health care system to Canada, France, the United Kingdom (U.K.), and Germany, and conclude that the ACA can be improved by changing the way in which the pharmaceutical industry functions by regulating the amount pharmaceutical companies spend on marketing drugs.

II. ACA COMPARED TO THE CANADA HEALTH ACT

The U.S. implemented the ACA to provide affordable care to all citizens, but this health care system does not compare to the success of other health care systems in the world.⁸ According to a report by the Commonwealth Foundation, the U.S. has the most expensive health care system in world but ranks last overall compared to eleven industrialized countries on the quality of its health system.⁹ Although the ACA allowed for more people to have health insurance, insurance is still by no means universal.¹⁰ Under the ACA approximately thirty million people remain uninsured.¹¹ On the other

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1022402/pdf/westjmed00067-0065.pdf>.

5. *Id.* The American Medical Association was founded in 1847 to improve hospital conditions and ensure that patients received quality care.

6. Palmer, *supra* note 2. The health care issue became the center of politics during President Truman's time and received his support despite anti-communist culture of America at that time. However, critics thought that compulsory health insurance was symbol of the Cold War and thought socialized medical care was a communist way of life.

7. Mary Mahon, *US Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives*, THE COMMONWEALTH FUND (2014) available at: <http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last>.

8. *Id.*

9. *Id.*

10. Michael Lee Jr., *Trends in the Law: The Patient Protection and Affordable Care Act*, 11 YALE J. HEALTH POL'Y L. & ETHICS, 1, 4 (2011).

11. *Id.*

hand, the Canada Health Act provides universal health care for all Canadian residents.¹² Unlike in the U.S., there are no financial restrictions to care at the point of service.¹³ For example, in Canada, costs are controlled because Canada pays ten percent of its gross domestic product (GDP) for its health care system, covering everyone.¹⁴

On the other hand, the ACA will do little to curtail insurance industry profits and will actually increase insurance industry profits.¹⁵ In the U.S., under the ACA, costs continue to rise.¹⁶ The U.S. pays eighteen percent of its GDP on health care and still does not cover millions of people.¹⁷ In Canada, the government negotiates drug prices so they are more affordable.¹⁸ In the U.S. under the ACA, Congress has banned the government from negotiating drug prices for volume purchases, so they remain unaffordable.¹⁹ These financial barriers exist because American pharmaceutical companies spend billions of dollars on marketing their drugs.²⁰

12. Jennifer L. Halser, *Canadian Pharmacies: A Prescription for A Public Health Disaster*, 54 DEPAUL L. REV. 543, 549 (2005).

13. Trudy Lieberman, *Comparing U.S., Canadian Health Care Systems*, ASS'N OF HEALTH CARE JOURNALISTS (2014) available at: <http://healthjournalism.org/blog/2014/01/comparing-u-s-canadian-health-care-systems/>.

14. Goran Ridic et al., *Comparisons of Health Care Systems in the United States, Germany and Canada*, 24 MAT. SOC. MED. 112, 112 (2012).

15. Bruce Japsen, *Despite Glitches, Obamacare Profit Windfall to Insurers Well Underway*, FORBES, Oct. 26, 2013, <http://www.forbes.com/sites/brucejapsen/2013/10/26/despite-glitches-obamacare-profit-windfall-to-insurers-well-underway/> (stating that health insurers are predicting an increase in revenues and profits as the ACA is implemented).

16. See generally, Melanie Evans, *Cost growth projected to climb; can ACA initiatives slow it down?*, MODERN HEALTHCARE, <http://www.modernhealthcare.com/article/20140906/MAGAZINE/309069983>.

17. AFL-CIO, *The U.S. Health Care System: An International Perspective*, THE DEP'T FOR PROF'L EMPLOYEES, 1, 4-13, (2014).

18. Zaheer Babar et al., *Evaluating Drug Prices, Availability, Affordability, and Price Components: Implications for Access to Drugs in Malaysia*. 4 PLOS MED, 466, 472 (2007).

19. Steve Maiken, *Obamacare Is Not True Universal Health Care While Under Corporate Control*, THE SUNDIAL CALIFORNIA STATE UNIVERSITY NORTHRIDGE, February 6, 2014, <http://sundial.csun.edu/2014/02/obamacare-is-not-true-universal-health-care-while-under-corporate-control>; See also: *U.S. Health Insurance Survey: 84 Million People Were Uninsured For A Time Or Underinsured In 2012*, SCIENCE DAILY, April 26, 2013, <http://www.sciencedaily.com/releases/2013/04/130426073856.htm>.

20. Hannah Keppler, *Pharmaceutical Company Profiteering: Behind the High Cost of Drugs in America*, EINSTEIN J. OF BIO. & MED., 1 (2014), available at: <http://theejbm.word>

Drug companies claim that they need to make billions of dollars on their medicines because of medical research and the risk of being unsuccessful.²¹ However, the U.S., with less than five percent of the world's population, buys more than half of its prescription drugs at prices aimed at funding the rest of the industrial world, where the same drugs cost much less.²² Pharmaceutical companies in the U.S. determine the price of prescription drugs, whereas pharmaceutical prices in Canada are subject to federal price limits.²³ The lack of regulation over pharmaceutical companies in the U.S. allows these companies to set drug prices whatever levels the market will allow.²⁴ By allowing this much autonomy, drug prices increase and as a result so do out-of-pockets costs for consumers.²⁵

III. ACA COMPARED TO THE FRENCH HEALTHCARE SYSTEM

The French health care system provides all citizens with health care by both private and governmental entities.²⁶ Although the French system is expensive, it provides universal coverage for every citizen.²⁷ On the other hand, American health care remains expensive and still leaves millions of people uninsured.²⁸ In 2007, pharmaceutical companies attempted to pass a bill in France that would allow for direct-to-consumer advertising (DTC).²⁹

press.com/2014/02/06/pharmaceutical-company-profiteering-behind-the-high-cost-of-drugs-in-america/.

21. Berry Werth, *A Tale of Two Drugs*, MIT TECH. REV. (2013), available at: <http://www.technologyreview.com/featuredstory/520441/a-tale-of-two-drugs/>.

22. *Id.*

23. Halser, *supra* note 12, at 553.

24. *Id.* at 550.

25. Martha Ann Holt, *International Prescription Drug Cost Containment Strategies And Suggestions For Reform in the United States*, 26 B.C. INT'L & COMP. L. REV. 326, 329 (2003).

26. Mira Radadia, *The High Cost of Health: The French System and What It Means for the U.S.*, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 14, 14 (2012).

27. *Id.*

28. *Id.* at 21-22.

29. Ray Moyniha, *Attempt To Undermine European Ban On Advertising Drugs Fails In France*, 334 BRITISH MED. J. 279, 279 (2007). Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1796687/>. The bill failed to pass because critics believed that the plan's purpose was to increase the amount of drugs consumed and thereby increase drug industry

French citizens believe that DTC is an advertising tactic with the purpose of increasing company profits and therefore did not allow the bill to pass.³⁰

The success of France's health care system is attributed to maintaining cost control over the health industry by regulating drug prices rather than engaging in DTC.³¹ The government approves drug prices, taking into account feedback from the manufacturers, and reimburses the manufacturers.³² By keeping the cost of drugs at a low price through regulatory measures, savings can be put towards complimentary health insurance for those who cannot afford it.³³ France is able to provide universal care and the U.S cannot reform to such a health care plan unless fundamental changes are made in the health care industry such as involving the government to set price limits for drug prices.³⁴

IV. ACA COMPARED TO THE UNITED KINGDOM'S NATIONAL HEALTH SERVICE PROGRAM

The United Kingdom's National Health System (NHS) is funded through taxation and provides a wide variety of free health services for individuals who are legal residents in the U.K.³⁵ In 2008, health care spending was sixteen percent of the GDP in the U.S., while it was only 8.7% in the U.K.³⁶

The NHS compensates for almost all drugs and approximately eighty-

profits.

30. *Id.*

31. Karen Bloor et al., *Lessons From International Experience In Controlling Pharmaceutical Expenditure III: Regulating Industry*, 313 *BMJ* 33, 33 (1996), available at: <http://www.jstor.org/stable/29732190>.

32. Radadia, *supra* note 26, at 21.

33. *Id.* at 20.

34. Maya Sabatello, *Disclosure of Gamete Donation in the United States*, 11 *IND. HEALTH L. REV.* 29, 75-76 (2014).

35. Leonard J. Nelson, III, *Rationing Health Care in Britain and the United States*, 7 *J. HEALTH & BIOMEDICAL L.* 175, 189 (2011).

36. David A. Squires, *The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations*, THE COMMONWEALTH FUND, 1, 2 (2011) available at: http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jul/1532_Squires_US_hlt_sys_comparison_12_nations_intl_brief_v2.pdf.

five percent of drugs are distributed at no cost to the patient.³⁷ Although the NHS does not directly regulate drug prices, the Pharmaceutical Price Regulation Scheme (PPRS) regulates companies' profits on sales to the NHS.³⁸ Therefore, drug companies can set the price of a new drug, but will be limited on the return rate of its capital for all products sold to the NHS.³⁹ The PPRS requires the return on capital for each product sold to the NHS to stay within the amount negotiated with that company.⁴⁰

If a drug company wants to increase the price of a drug, it must seek approval from the PPRS.⁴¹ However, drug prices can be lowered without asking for approval.⁴² Additionally, the NHS allows consumers to pay a flat fee per prescription or a certain amount annually for an unlimited number of prescriptions.⁴³ These regulations have allowed for less government spending in pharmaceutical companies resulting in universal health care for all citizens in the U.K.⁴⁴

The most practical way for the U.S. to have affordable care is to use the process the U.K. has implemented. Because drug regulation is banned in the U.S.,⁴⁵ an easier route for the government would be to set up a program similar to the PPRS in which the government would not directly regulate drugs but assign caps to how a pharmaceutical company can profit off a drug. If the U.S. implements such a policy, it could reduce the cost of drugs and thereby spend less of its GDP to fund the healthcare system. The money saved from drug cost and marketing would be put towards funding a

37. Michele L. Creech, *Make A Run for the Border: Why the United States Government Is Looking to the International Market for Affordable Prescription Drugs*, 15 EMORY INT'L L. REV. 593, 619 (2001).

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.* at 619-20.

44. *Id.* at 620.

45. Maiken, *supra* note 19.

PPRS program and inexpensive drugs could finally be accessible to the public.

V. ACA COMPARED TO GERMANY

Germany has a broad national health service that provides universal health care for the entire population.⁴⁶ Germany's health care system is decentralized and funded by taxes, co-payments, and workplace contributions.⁴⁷ The health care system includes nonprofit insurance funds that provide coverage for everyone except the wealthiest percentage of the population, who can buy private insurance coverage.⁴⁸

Similar to those in the U.S., drug companies in Germany have the freedom to price prescription and generic drugs.⁴⁹ Additionally, such companies can change the prices at their own will.⁵⁰ Unlike the U.S. however, Germany's health care system controls reimbursement by classifying drugs into groups based on which drug has a close substitute.⁵¹ Then each group has set a single price that is the cap reimbursement price for all drugs in the group.⁵² The process by which Germany implements its health care system allows for cost control that results in universal and affordable care for all its citizens. In order for the U.S. to be truly affordable, it could implement some of the policies that Germany utilizes such as capping reimbursement for drugs. By doing this, drugs will be more affordable in the U.S. and the excess money the government uses to support pharmaceutical spending can be used to expand the ACA to every citizen at a low cost.⁵³

46. Creech, *supra* note 37, at 620.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* While manufacturer prices remain unregulated, patients must pay any excess of manufacturer's price over the reference price. As a result, demand is highly elastic above the established reference price. Certain major drugs are exempt from reference pricing. For the majority of drugs, reference prices are reviewed every year.

53. Michael Adams, *Florida Approves Cap on Physician-Dispensed Drugs for Work-*

VI. DIRECT-TO- CONSUMER MARKETING IN THE U.S IMPACTS HEALTH CARE COSTS

The common denominator in international healthcare systems mentioned above is that each has some process to regulate pharmaceutical drugs. In order for the U.S. to be a contender in the list of countries with the best healthcare systems, it must change the way pharmaceutical companies function. One of the biggest factors that contributes to the cost of drugs in the U.S. is the high expense incurred through marketing and lobbying efforts.⁵⁴ Prescription drug prices in the U.S. are high in order to balance the costs that pharmaceutical companies spend on marketing their products.⁵⁵ In the U.S., not only does DTC advertising raise the cost of drugs, it can have adverse effects on the public due to misinformation.⁵⁶ In a poll cited by the bill maker, forty-three percent of individuals surveyed thought only completely safe drugs could be advertised and twenty-one percent thought only very effective drugs could be advertised.⁵⁷

The U.S. spends approximately one thousand dollars per person per year on pharmaceuticals.⁵⁸ This is twice as much as France and Germany and roughly forty percent more than Canada.⁵⁹ Prices in the U.S. for brand-name patented drugs are fifty to sixty percent higher than in France and twice as high as in the U.K.⁶⁰ The reason for this discrepancy is that most European countries have centralized health care systems in which govern-

ers' Compensation, INSURANCE JOURNAL, (2013), available at: <http://www.insurancejournal.com/news/southeast/2013/05/02/290595.htm>. At the state level, Florida put a cap on how much physicians can charge for prescription drugs. Pharmacies reimbursements will be maintained at a drug's average wholesale price plus a small fee. This deal is expected lower overall insurance costs by \$20 million.

54. Halser, *supra* note 12, at 550.

55. *Id.* at 551.

56. Bradley D. Kay, *Is the Cure Worse Than the Disease? The Direct-to-Consumer Advertising Exception*, N.Y. ST. B.J., 30, 32 (2009).

57. *Id.*

58. Valerie Paris, *Why Do Americans Spend So Much On Pharmaceuticals?*, PBS NEWS HOUR (2014), available at: <http://www.pbs.org/newshour/updates/americans-spend-much-pharmaceuticals/>.

59. *Id.* at 2.

60. *Id.* at 3.

ment agencies regulate the prices of medicines and set limits to the amount for which they will compensate.⁶¹

In the U.S., however, insurers agree to the price determined by drug-makers and cover the cost with large copayments.⁶² If there are competing drugs, insurers possess more bargaining power and have the ability to negotiate prices with manufacturers in exchange for lower cost sharing for patients.⁶³ In off-patent markets, the competition is fierce and prices of generic drugs are low.⁶⁴ Generic drug dispersion is increasing in the U.S. and typically within six months of a patent expiring on a drug, the generic substitute will account for eighty percent of the market.⁶⁵ Generics drugs account for twenty-eight percent of pharmaceutical expenditures and eighty-four percent of drugs distributed in the U.S.⁶⁶

Additionally, drug companies spend twice as much on marketing drugs than on research and development.⁶⁷ This is because there is no regulatory system in place to monitor pharmaceutical spending and American taxpayer dollars go towards initial research and development, which allows pharmaceutical companies to focus profits on marketing tactics.⁶⁸ This results in Americans paying for drugs twice: first, through taxes used to finance initial research and development, and then second by paying for the expensive drugs which are priced high because of marketing costs.⁶⁹

However, the ACA does not provide any incentive for pharmaceutical companies to lower prices and it does not adopt any of features used by European countries capping the cost of the drugs.⁷⁰ Rather than market drugs

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. Paris, *supra* note 58, at 3.

67. Kepler, *supra* note 20, at 2.

68. *Id.*

69. *Id.*

70. *Id.*

directly to consumers the U.S could implement a program similar to the one provided by the, European Commission.⁷¹ This program allows manufacturers to certify the efficiency of their drugs with the European Economic Community, the European Agency for the Evaluation of Medicinal Products and present them to the marketplace.⁷² Europe controls increasing health care costs by regulating the drug market.⁷³ By contrast, the prices of most drugs in the U.S. will increase and so will the profit margins for pharmaceutical companies.⁷⁴ As a result, affordable care will be an unreachable goal for the U.S. In order to be truly accessible and affordable the U.S. must learn from its international counterparts on how to manage pharmaceutical spending. By regulating marketing practices and controlling the cost of drugs, the government will ensure that pharmaceutical companies spend less on business tactics, and that money can be used to implement programs that can regulate pharmaceutical spending.

VII. CONCLUSION

Access to affordable health insurance and health care are factors that are remediable with reasonable effort, as is demonstrated by the fact that the United States is alone among industrialized countries in failing to guarantee at least some level of basic, non-emergency care for its population.⁷⁵ Although prescription drug spending is a small portion (11%) of personal health care spending, it is one of its fastest growing areas, increasing at fast rates in each of the past seven years.⁷⁶ Limiting how much pharmaceutical

71. Adam R. Young, *Generic Pharmaceutical Regulation in the United States with Comparison to Europe: Innovation and Competition*, 8 WASH. U. GLOBAL STUD. L. REV. 165, 181 (2009).

72. *Id.*

73. *Id.* at 180.

74. Kepler, *supra* note 20, at 2.

75. Emily Whelan Parento & Lawrence O., Gostin, *Better Health, but Less Justice: Widening Health Disparities After National Federation of Independent Business v. Sebelius*, 27 NOTRE DAME J.L. ETHICS & PUB. POL'Y 481, 512 (2013).

76. The Henry J. Kaiser Family Found., *Impact of Direct-to-Consumer Advertising on Prescription Drug Spending*, June 2003, available at:

companies spend on marketing could provide for more funding in other areas of public health.

Congress should limit DTC advertising for pharmaceutical companies. By doing this, these drug companies will cut their marketing costs and use those savings on producing cheaper drugs. This will allow for the government to spend less of the health care budget on drug costs and use it towards expanding the ACA to provide accessible and affordable care for everyone.