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Allison K. Hoffman

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# HEALTH CARE SPENDING AND FINANCIAL SECURITY AFTER THE AFFORDABLE CARE ACT\*

ALLISON K. HOFFMAN\*\*

*Health insurance has fallen notoriously short of protecting Americans from financial insecurity caused by health care spending. The Patient Protection and Affordable Care Act (“ACA”) attempted to ameliorate this shortcoming by regulating health insurance. The ACA offers a new policy vision of how health insurance will (and perhaps should) serve to promote financial security in the face of health care spending. Yet, the ACA’s policy vision applies differently among insured, based on the type of insurance they have, resulting in inconsistent types and levels of financial protection among Americans.*

*To examine this picture of inconsistent financial protection, this Article offers a taxonomy to describe ways in which health insurance regulation can promote financial security. It then uses this taxonomy to map the effect the ACA will have on the financial security of various insured populations. Specifically, it analyzes how much a person in poor health might spend out of pocket on health care in three scenarios: a person with average coverage through an individual-market health insurance exchange, a worker with employer-sponsored insurance, and a retiree with Medicare and a supplemental insurance plan. This analysis reveals two effects. First, the ACA alleviates financial risk from health care spending to some degree in all three scenarios. But, second, the ACA preserves (and may even exacerbate) variability in the degree and type of financial risk remaining across the three scenarios. In effect, the ACA asserts and affirms different visions of the role of health insurance in promoting financial security for different people. This*

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\*\* Assistant Professor, UCLA School of Law. Thank you to Asli Bali, Sam Bray, Jill Horwitz, Russell Korobkin, Jason Oh, Joanna Schwartz, Rebecca Stone, Alex Wang, Steve Yeazell and to the participants at the *North Carolina Law Review* Symposium for helpful feedback. A special thank you to Scott Chandler for superb research assistance.

*inconsistency leaves some insured especially vulnerable to spending and creates complexity that may impede insured from comprehending these points of vulnerability.*

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## INTRODUCTION

A central goal of health insurance is to protect people from financial insecurity caused by spending on medical care.<sup>1</sup> Yet, historically, health insurance in the United States has failed to ensure

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1. See Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1908–12 (2011) (describing one goal of health insurance as promoting financial security). Insurance can serve other purposes as well. Insurance provides access to hospitals and doctors in hopes of promoting health. See *id.* It also can help shape behaviors through incentives and pricing structures. See *id.*

sufficient financial protection for many Americans.<sup>2</sup> People have struggled to pay high premiums, their share of costs when their insurance pays only for part of their care, or the cost of care not covered by insurance at all. Health care spending is a major factor in bankruptcy filings, both for insured and uninsured Americans.<sup>3</sup> Elizabeth Warren remarked that “[e]very 30 seconds in the United States, someone files for bankruptcy in the aftermath of a serious health problem.”<sup>4</sup> Even when health care spending does not push a household all the way to bankruptcy, it can nonetheless cause financial and emotional stress.<sup>5</sup>

The Patient Protection and Affordable Care Act (the “ACA”)<sup>6</sup> attempted to ensure that Americans would have adequate health insurance, in part to reduce these threats to financial security. Before the ACA was enacted into law, President Barack Obama testified to Congress: “That’s what Americans who have health insurance can expect from this plan—more security and stability.”<sup>7</sup>

Yet, even after full implementation, Americans will enjoy different types and levels of financial protection, depending on their source and type of insurance. This is because the ACA is built on a complex structure of insurance design and regulation. The ACA

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2. See, e.g., JACOB S. HACKER, *THE GREAT RISK SHIFT* 139 (2006) (noting that “today, medical costs and insurance are at the heart of insecurity in the United States”); David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. W5-63, W5-72 (2005), <http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63.full.pdf+html> (noting that “middle-class Americans . . . face impoverishment following a serious illness”); David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009) (finding that medical bills contribute to many bankruptcies); Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL’Y L. & ETHICS 239, 240, 286 (2010) (claiming that the court-record method, which involves looking at the court documents submitted by bankruptcy filers, “is an unreliable measure of the financial burden of illness or injury faced by bankruptcy filers” and underrepresents the actual hardship). See generally Jacob S. Hacker, *Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States*, 98 AM. POL. SCI. REV. 243 (2004) (arguing that the convergence of stagnant policies, including health policy, and changing social realities have left Americans more financially vulnerable).

3. See *supra* note 2 and accompanying text.

4. Elizabeth Warren, *Sick and Broke*, WASH. POST, Feb. 9, 2005, at A23.

5. See, e.g., HACKER, *THE GREAT RISK SHIFT*, *supra* note 2 at 138–40.

6. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified as amended primarily in scattered sections of 42 U.S.C. (2012)).

7. President Barack Obama, Health Care Address to Congress (Sep. 9, 2009) (transcript available in the N.Y. Times, [http://www.nytimes.com/2009/09/10/us/politics/10obama.text.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2009/09/10/us/politics/10obama.text.html?pagewanted=all&_r=0)).

preserves, and even intensifies the effect of, a health insurance system fragmented between many types and sources of insurance, each governed by different regulators and regulations.<sup>8</sup>

This Article illuminates the resulting inconsistent picture of financial risk for Americans by examining how much a member of different insured groups might spend out of pocket on health insurance and medical care after the ACA is fully implemented. The difficult normative question, which this Article only begins to answer, is whether the ACA's approach, even if inconsistent, might make sense, either politically or normatively. This Article reveals the places where this inconsistency leaves some insured especially vulnerable, even after full ACA implementation, and questions whether these remaining gaps are defensible. This Article additionally illustrates how the ACA adds to the complexity of health care spending risk, which could make it difficult for Americans to comprehend.

As a precursor to critical examination, Part I of this Article offers an original taxonomy of four different aspects of financial risk that health policy could attempt to reduce. First, health care regulation could reduce baseline spending so that most people who are in relatively good health spend little on premiums and on medical care in a given year. Second, it could reduce potential variability in spending, making what an insured is likely to spend more predictable, whether in a year of good or bad health. Third, it could reduce catastrophic risk, so that, even if unpredictable, spending would never rise to an unmanageable level for any individual, no matter how much medical care she may need. Finally, even if none or all of the above were true, regulation could increase transparency so that Americans could understand how much they might spend on health care and how the amount might vary based on their health. Depending on which of these aspects are emphasized, health insurance regulation pursues the goal of improved financial security in different ways.

Part II then traces which aspects health policy—including the ACA—emphasizes for different groups of insured, by examining three stylized scenarios of health insurance and spending. These three scenarios, considered together, represent the most common ways Americans will obtain health insurance. They are: (1) a person who buys an average, or “silver-level,” plan on an individual health insurance exchange; (2) a worker who has a health insurance plan

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8. For a detailed discussion of this “fragmented” structure, see generally Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7 (2010).

from her employer; and (3) a retiree with Medicare and Medigap private insurance. Examining these three common cases necessarily leaves out a number of others, including Medicaid beneficiaries, people buying individual market coverage outside of exchanges, and those with military coverage. Furthermore, because these examples are stylized, and not modeled based on individual characteristics, they are meant to be rough illustrations, not precise estimates. The goal of this Article is not to estimate spending for every insured but rather to illustrate the variability of financial protections—and different visions of how regulation can promote financial security—for members of the most common groups of insured.

This Article's analysis paints three different pictures of financial security for different insured groups after full implementation of the ACA, explored in Part III below. Each picture emphasizes ameliorating different aspects of financial risk.

For the person who buys individual coverage from a new health insurance exchange, the ACA defines security as insurance protection against catastrophic spending on essential medical care, but requires moderate to high baseline spending on premiums and cost sharing, even in a healthy year. This model best captures traditional economic notions of insurance.

For the worker with insurance through her employer, the ACA perpetuates a regulatory approach that largely allows employers to determine what role insurance coverage will play in protecting her from financial threats. With this deferential approach, the ACA preserves a system where employees currently enjoy low baseline spending in a typical year and little variable spending, even in a year of bad health. It also preserves the possibility that a worker could face catastrophic risk from spending on any items and services an employer decides not to cover, which could in theory include essential medical care.

For retirees, Medicare policy defines security in two different ways, which are preserved and reinforced by the ACA. A minority of retirees with only Original Medicare and no supplemental coverage enjoy low baseline spending but face high potential for variable spending and catastrophic risk. This structure results in low financial risk for the typical, reasonably healthy retiree but leaves those with more serious medical needs vulnerable. Yet, most retirees buy supplemental insurance coverage for additional protection, choosing instead a definition of financial security that includes high premiums but limited variable spending on covered benefits. This second

picture is structurally similar to that for exchange enrollees in some ways (high baseline spending and low catastrophic risk). But, after the ACA, retirees face relatively greater financial risk from three sources: higher premiums, the potential for spending on uncovered care, and the complexity of insurance terms. Retirees are arguably the most vulnerable to financial risk from health care spending in a post-ACA world.

There are reasons why the ACA's inconsistent approach may be socially beneficial, especially to the degree this inconsistency helped to pass legislation that improves financial security overall. But some aspects of the ACA's approach, or its omissions, leave insured people highly exposed to certain aspects of financial risk, as examined in Part III. For example, after the ACA is implemented, retirees arguably will be less protected from both baseline and catastrophic spending than younger workers who buy exchange coverage. In effect, the ACA has raised the bar for many younger Americans but left older ones behind. Furthermore, health insurance regulations, both those predating and in the ACA, create a level of complexity that is welfare reducing to the extent it prevents Americans from understanding and managing health care spending risk. Once the implementation dust settles, it is critical to reexamine the places where the greatest financial risk from health care spending remains and to continue to work to ameliorate it as necessary. This Article provides a foundation for such examination.

### I. THE GOAL OF FINANCIAL SECURITY AND ROLE OF HEALTH INSURANCE REGULATION

Insurance can reduce threats to financial security by distributing health care spending. First, it distributes health care spending intertemporally, evening out any one person's total lifetime spending year-to-year. In this way, insurance is a savings or borrowing device. A person pays premiums every year and draws from these funds when she needs medical care. Second, it can distribute health care expenditures among a population, interpersonally. Health care use and expenditures are notoriously skewed among the U.S. population. The top 30% of spenders account on average for over \$12,000 each in health care expenditures, the top 10% for nearly \$27,000 each, and the top 1% for an astounding \$90,000 each.<sup>9</sup> Health insurance

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9. NAT'L INST. FOR HEALTH CARE MGMT., THE CONCENTRATION OF HEALTH CARE SPENDING: NIHCM FOUNDATION DATA BRIEF 3 fig.2 (Jul. 2012), *available at* <http://www.nihcm.org/pdf/DataBrief3%20Final.pdf>; *see also* Marc L. Berk & Alan C.

distributes these expenditures among a “risk pool,” so that everyone contributes to the pool’s funds by paying premiums and the unhealthy draw from these funds to pay for needed medical care. These two types of distribution can smooth spending so that, in an ideal world, no one individual would bear unaffordable health care expenses in any one year.

Despite its ability to smooth spending, which should make it easier for individuals to afford needed medical care, health insurance has not always protected Americans well from health care spending risk. Several different threats can cause even someone with health insurance to struggle to finance her health care needs.

People with health insurance may struggle to pay high premiums. High premiums might result when an insured is part of a “bad” insurance risk pool, where many people use a large amount of expensive care. The result is that even with interpersonal distribution of spending in the risk pool, the average cost per person and, in turn, the average premium, is high. This problem is exacerbated by the overall growth in health care spending over the past few decades.<sup>10</sup> High premiums might also result when costs are not distributed evenly among members of a risk pool. In the United States, unlike in most countries, insurers have historically been able to “experience” or risk-rate policies, charging higher premiums to applicants they think might spend more on health care, based on their individual health profile or other attributes such as sex or age.<sup>11</sup> The result is that some people are charged relatively higher premiums and others relatively low ones. With high premiums, the cost of health insurance alone could add to the feeling of financial *insecurity* for an insured, even before she uses any medical care.

In addition, an insured might struggle to pay her share of costs when she uses medical care. She might face high spending if her policy, sometimes referred to as “bare-bones” insurance, requires her to pay a high proportion of the cost of covered benefits she uses. For example, a policy might require that she pay 20% of any

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Monheit, *The Concentration of Health Care Expenditures, Revisited*, HEALTH AFF., Mar.–Apr. 2001, at 9 (indicating “a relatively small proportion of the population accounting for a large share of expenditures”). Among Medicare beneficiaries, the picture is similar. The top 5% spent an average of over \$62,000 each in 2004. Gerald F. Riley, *Long-Term Trends in The Concentration of Medicare Spending*, 26 HEALTH AFF. 808, 811 fig.2 (2007).

10. HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: KEY INFORMATION ON HEALTH CARE COSTS AND THEIR IMPACT 1 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf>.

11. See, e.g., LAWRENCE O. GOSTIN & PETER D. JACOBSON, LAW AND THE HEALTH SYSTEM 340 (2006).



hospitalization or doctor visit. Or the policy might include a deductible, where she pays for the first \$5,000 in medical care before the plan begins to pay for care. Another source of high out-of-pocket costs is when insurance benefits are not comprehensive. For example, an insurance policy could exclude benefits for certain medical conditions, such as certain fertility care or HIV care, in which case the insured would have to pay for the entire cost of any care she uses for these conditions.

Out-of-pocket spending can be catastrophic for someone who is particularly unlucky or unhealthy and needs substantial medical care, even if the individual has coverage that would be adequate in most situations.<sup>12</sup> It is not uncommon for someone to have substantial needs over multiple years,<sup>13</sup> which would pose financial strain to nearly all families if this spending were not adequately mitigated by insurance.

Finally, financial insecurity can be exacerbated by the opacity of the terms of health insurance coverage. Even if the out-of-pocket health care spending required under a policy—for premiums and cost sharing—is predictable, if consumers do not understand the terms of the policy well enough to predict their own required spending, they will fail to budget for it. Decisions regarding health insurance and health care, which affect spending, tend to be some of the most complex financial decisions people have to make. Studies have shown that people fail to understand the potential for catastrophic risk.<sup>14</sup> In other words, they fail to understand how much more they might spend if they have a year of bad health than they would in the typical year.<sup>15</sup> Thus, even those people who could in theory protect

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12. Extremely high spending is concentrated among older and less healthy individuals. NAT'L INST. FOR HEALTH CARE MGMT., *supra* note 9, at 4 fig.3 (demonstrating that people over sixty-four make up 40% of the top 1% of spenders on health care, but just 13% of the total U.S. population).

13. *See id.* at 6 ("Forty-five percent of those in the top decile of spending in 2008 and one in five of those in the very highest spending group remained in that group in the next year.").

14. *See, e.g.,* Allison K. Hoffman & Howell E. Jackson, *Retiree Out-of-Pocket Healthcare Spending: A Study of Consumer Expectations and Policy Implications*, 39 AM. J.L. & MED. 62, 68 (2013) ("Furthermore, they underestimated the potential effect of individual health experience, which can result in an individual having double to triple expenditures of the typical retiree; only a fifth of all respondents estimated that adverse health experience could lead to a more than 50% increase in out-of-pocket costs. To oversimplify, some people know costs; few know risk.").

15. *See id.*; NAT'L INST. FOR HEALTH CARE MGMT., *supra* note 9, at 11.

themselves against high out-of-pocket expenditures are generally not aware of what it would take to do so.<sup>16</sup>

There is wide consensus that one important goal of health insurance regulation is to reduce these threats and to promote financial security in light of health care spending. However, there is no consensus on how to best maximize financial security. The following original taxonomy delineates four different ways health care policy might try to maximize financial security in the face of health care spending. By emphasizing one (or more) of these aspects, policies implicitly give meaning to the goal of financial security and determine how health insurance will help promote this goal.<sup>17</sup>

1. Financial security might be maximized when a person spends as little as possible on health care in a typical, relatively healthy year, determined mostly by health insurance premiums, in light of low use of medical care.<sup>18</sup>

This is a definition of financial security as *low baseline spending*.

2. Financial security might be maximized when an individual's spending, especially on benefits covered by a plan, is not widely variable. Although someone might predictably spend a predetermined amount on health care in a typical year, she can assume that her out-of-pocket spending will vary little from this amount, even in a year of bad health. In recent years, the potential for variable spending, especially on covered benefits, has increased with the growth of high-deductible health plans or other plan designs that require high cost sharing.<sup>19</sup> These plans may cause some people to underuse necessary care to avoid spending money on it,<sup>20</sup> or, if they do use care, to struggle

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16. See generally Hoffman & Jackson, *supra* note 14 (finding that a disproportionate number of Americans estimate their future out-of-pocket health care costs to be substantially below what experts predict).

17. Cf. WILLIAM N. ESKRIDGE JR. & JOHN FEREJOHN, A REPUBLIC OF STATUTES 6–7 (2010) (describing how statutes can “fill in the huge holes in our governance structure and norms” or entrench norms over time).

18. See, e.g., KAREN DAVIS, THE COMMONWEALTH FUND, WHY HEALTH REFORM MUST COUNTER THE RISING COSTS OF HEALTH INSURANCE PREMIUMS (2009), available at [http://www.commonwealthfund.org/~media/Files/Publications/Blog/Davis\\_Blog\\_August\\_09\\_rev.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Blog/Davis_Blog_August_09_rev.pdf) (“Health insurance is already becoming unaffordable for families and businesses, with premium inflation outpacing wage increases.”).

19. See generally TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT (2007) (describing and criticizing the rise of Consumer-Driven Health Care and high deductible health plans).

20. See, e.g., JONATHAN GRUBER, HENRY J. KAISER FAMILY FOUND., THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 9 (2006), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7566.pdf> (discussing various studies on the

to finance it.<sup>21</sup> In addition, low variability is important for some people so they can plan spending in a way that maximizes their welfare, allocating neither too much nor too little of income to health care or health savings accounts.

This is a definition of financial security through *low variability in spending*.

3. Financial security might be maximized when variable spending is no more than any one particular person could handle, based on individual assets, income, and other expenses.<sup>22</sup> Professors Michael Graetz and Jerry Mashaw define financial security as protection against the risk of falling below a “decent” income level or the risk of an “unacceptably steep decline in living standards” caused by medical spending.<sup>23</sup> Regulation taking this approach might allow variability in spending, even high variability for high-income Americans, so long as the variability is tied to what is reasonable based on an individual’s resources. This vision requires defining what “decent” means and what constitutes an “unacceptable steep decline,” as well as the right timeframe for measuring spending burden (e.g., over the course of one year or over a lifetime).<sup>24</sup>

This is a definition of financial security as *no catastrophic risk*.

4. Regardless of the level of risk along the aforementioned dimensions, financial security could be maximized through

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elasticity of demand for various medical treatments); JOSEPH P. NEWHOUSE & THE INS. EXPERIMENT GRP., *FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* 339–40 (1993) (summarizing results of the RAND health experiment, including an adverse effect on the health of the sick poor with increased cost sharing); M. Gregg Bloch, *Consumer-Directed Health Care and the Disadvantaged*, 26 HEALTH AFF. 1315, 1318 (2007) (explaining that the consumer-directed health care model does not necessarily “inspire[] patients to economize wisely”); Sara R. Collins, *Consumer-Driven Health Care: Why it Won’t Solve What Ails the United States Health System*, 28 J. LEGAL MED. 53, 55 (2007) (reviewing literature on effect of high-deductible plans on health); Thomas Rice & Karen Y. Matsuoka, *The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors*, 61 MED. CARE RES. & REV. 415, 420–26 (2004) (detailing the effect of cost-sharing on the health and mortality of seniors).

21. See, e.g., Alison A. Galbraith et al., *Nearly Half Of Families In High-Deductible Health Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden*, 30 HEALTH AFF. 322, 322 (2011) (describing the results of an empirical study of the financial burden of plans with deductibles of at least \$1,000 per individual or \$2,000 per family for people with chronic conditions).

22. See, e.g., MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY* 146 (1999) (“[I]t is the job of social insurance to protect family income streams . . .”).

23. *Id.* at 171.

24. See Hoffman, *supra* note 1, at 1915–16 (discussing different ways to measure these metrics).

transparency.<sup>25</sup> In other words, no matter how much an individual might spend, the range of possible spending would be obvious to that individual.

This is a definition of financial security through *transparency*.

This Article focuses on financial regulation with regard to the first three aspects of financial risk, in particular, but notes where lack of transparency exacerbates risk in the scenarios below.

Both prior to and as part of the ACA, three key types of regulatory tools are used to attempt to ameliorate financial risk: pricing regulation, cost-sharing limits (regulating deductibles, copayments, or coinsurance when someone uses medical care covered by a policy), and coverage regulation (mandated coverage of certain benefits). Pricing regulations limit what any one individual might spend on premiums by spreading the costs of health care more evenly over someone's lifetime or among all insured. Such regulation includes, for example, community rating, which requires that insurers charge the same premium to everyone who chooses a particular health insurance plan. The second and third types of regulation attempt to limit variable out-of-pocket spending on medical care and to reduce catastrophic risk.<sup>26</sup> Cost-sharing limits explicitly cap what any one individual might have to pay out of pocket for covered services, curbing variable spending and catastrophic risk due to "bare bones" coverage. Coverage regulations, or "mandated benefits," ensure common or critical treatments are covered by a policy. These rules limit what an individual might have to fund completely out of pocket. Examples include state laws mandating coverage of benefits for designated medical conditions or populations<sup>27</sup> and the essential

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25. See, e.g., Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394, 396 (2014) ("A central goal of financial regulation is to promote markets that are more transparent for consumers and retail investors."); Karen Pollitz & Larry Levitt, *Health Insurance Transparency under the Affordable Care Act*, HENRY J. KAISER FAMILY FOUND. (Mar. 8, 2012), <http://kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/> (describing ACA provisions that protect consumers by requiring reporting of policy terms and payment practices).

26. Other regulations, which are not detailed herein, can attempt to ensure a sufficient network of providers to offer these services. If provider shortages become a problem with increased insurance coverage, these regulations could become increasingly important over time.

27. See, e.g., *State Health Insurance Mandates and the ACA Essential Benefits Provisions*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx> (last updated Jan. 2, 2014) (describing the use of mandated benefit laws by the states before and after the ACA's creation of "Essential Health Benefits").

health benefits required under the ACA, discussed below. In addition to these regulations, subsidized or free health insurance is often provided to low-income households for additional protection, as in the case with the Medicaid program and the new premium and cost-sharing subsidies under the ACA, discussed below.<sup>28</sup>

This Article suggests that through its regulatory provisions, as well as its omissions, the ACA offers a new *de facto* definition of how health insurance will (and perhaps should) be structured to better promote financial security. This definition is, however, inconsistent among different insured groups because health policy emphasizes different aspects of financial security for different types of insurance.

## II. REGULATION AND FINANCIAL SECURITY AFTER THE AFFORDABLE CARE ACT

This Part examines the post-ACA picture of financial security for different groups of insured, by considering the level and types of financial risk from health care spending that an individual with moderate income and in poor health could face in each of three stylized scenarios. These three scenarios together represent how the majority of Americans will get insurance: (1) a person buying health insurance on the individual market exchanges; (2) a worker who has coverage through an employer; and (3) a retiree with Medicare. Estimates are based on what an individual who earns the median household income<sup>29</sup> and who has median household assets might

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28. See *infra* notes 87–89 and accompanying text.

29. Part II uses median gross household income by age group (over sixty-five or under sixty-five) for a rough estimation. Reliance on this approximation is admittedly imprecise in several ways. First, income differs based on the characteristics of the member(s) of the household, including number of people, race, geography, and gender, as well as type of insurance. The stylized scenarios below do not attempt to model income based on these particular characteristics, nor do they intend to make precise estimates of insurance costs based on such characteristics. Rather, they offer a rough estimate of possible spending for an illustrative member of each group of insured with moderate income and in poor health to show what spending exposure might be for someone who does not qualify for subsidies on the exchanges or in the Medicare program. Thus, the scenarios do not attempt to capture the ways in which health care spending is disparately burdensome demographically. Second, the analysis below relies primarily on gross income, rather than a measure of after-tax income for two reasons. One is that gross income is often used for rough budgetary benchmark discussions with respect to a particular good. Another is that gross income is the best data available separately for both those under age sixty-five and those over age sixty-five. However, with regard to non-retirees, I note spending as a percentage of median U.S. adjusted gross income as well to give a sense of how much of a household's take-home pay might be consumed by health care spending. The first two scenarios (exchange coverage and ESI) are based on gross income for households under age sixty-five, which was \$57,353 in 2012. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS

spend out of pocket on health care, premiums, cost sharing, and uncovered care. These out-of-pocket spending estimates are based on the formal limits set in the ACA and on early empirical projections of spending for different populations. They illuminate the post-ACA de facto definitions of how health insurance will protect the financial security of different populations.

*A. Overview of the Regulation of Health Insurance Before and After the ACA*

Unlike in most developed countries, there is no one primary system for health care financing in the United States, and the many types of health care financing are often regulated differently.<sup>30</sup> The ACA is built on this complex structure of insurance design and regulation, and it perpetuates and exacerbates this complex structure. The result is that the financial protections insured enjoy differ depending on the type of insurance they have and, often, on where they live.

Health insurance is divided between public and private coverage. Public coverage is available to about one-third of Americans who qualify through one of several programs,<sup>31</sup> including Medicare for people over age sixty-five and people who are disabled, Medicaid for qualifying low-income individuals, and military coverage for active service people, veterans, and their families.<sup>32</sup> Private health insurance,

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BUREAU, CURRENT POPULATION REPORTS: INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2012, at 6 tbl.1 (2013), *available at* <https://www.census.gov/prod/2013pubs/p60-245.pdf>. Although I assume the same income for both scenarios, exchange enrollees, as a group, will likely have lower income than those with coverage through an employer for two reasons. The first is that, by definition, they do not have jobs with health benefits, and those jobs tend to be lower-income jobs. The second is that because of the subsidies discussed herein, lower-income people have more incentive to enroll in exchange coverage. For the Medicare scenario, I consider median income among people over age sixty-five, which was \$33,848 in 2012. *Id.* This estimate, like any single measure applied to a large and diverse population, is both too high and too low. For example, the median single woman over age sixty-five earns much less than the median single man or household with a married couple over age sixty-five, in part due to declining income with age and the fact that women live longer. Median adjusted gross income for the entire population was just under \$35,000 in 2011, the last year of data available. STATISTICS OF INCOME DIVISION, INTERNAL REVENUE SERV., 2013 TAX STATISTICS 2 (2013) (reporting adjusted gross income of \$34,794, based on tax year 2011 returns).

30. See GOSTIN & JACOBSON, *supra* note 11, at 334–39.

31. See DENAVAS-WALT ET AL., *supra* note 29, at 26 tbl.8 (reporting 33% of Americans have government insurance, of whom 16% have Medicare, 16% have Medicaid, and over 4% have military health care (note that these groups are not mutually exclusive)).

32. See *id.*

which is the sole available coverage for most people below age sixty-five, is offered in three main “markets”—large group employer-sponsored insurance (“ESI”) for employee groups with over fifty people, small group ESI for groups with fewer than fifty people, and “individual market” coverage, where someone buys a policy directly from an insurance company.<sup>33</sup> In 2011, before full ACA implementation, an estimated 64% of the U.S. population had private health insurance, most through an employer.<sup>34</sup> Nearly 16% of the population was uninsured.<sup>35</sup>

Different regulatory bodies and substantive requirements govern each type of insurance. Private health insurance regulation is reserved to the states, unless the federal government explicitly expresses its intention to regulate.<sup>36</sup> The federal government can in theory create rules that apply consistently across all types of insurance. Several federal laws, for example, mandate coverage of specific benefits in health plans to protect individuals from health discrimination. These laws require plans to cover certain maternity-related benefits<sup>37</sup> and to have parity in coverage of mental health and substance abuse disorder benefits, on the one hand, and medical and surgical benefits, on the other.<sup>38</sup>

But before the ACA, the federal government rarely regulated health insurance and, even when it did, often chose to apply different substantive rules to different types of insurance. For example, one important federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),<sup>39</sup> prohibited employers from discriminating against employees based on health status,<sup>40</sup> limited the

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33. HENRY J. KAISER FAMILY FOUND., *HOW PRIVATE INSURANCE WORKS: 2008 UPDATE 1*, 18 (2008), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7766.pdf> (discussing the divide between employer-sponsored insurance and individual coverage and how regulations “vary by market segment (e.g., large group, small group, or individual coverage)”).

34. DENAVAS-WALT ET AL., *supra* note 29, at 26 tbl.2.

35. *Id.*

36. See 15 U.S.C. § 1012 (2012) (giving states the authority to regulate the “business of insurance” unless federal law specifically intends to regulate insurance).

37. See 29 U.S.C. § 1185.

38. See § 1185a.

39. Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of the U.S. Code).

40. § 1182 (“[p]rohibiting discrimination against individual participants and beneficiaries based on health status”). While the terms might be facially neutral, however, employers could still exclude whole categories of treatment in a way that might have a disparate impact on employees. See, e.g., *McGann v. H & H Music Co.*, 946 F.2d 401, 403, 408 (5th Cir. 1991) (holding that an employer who reduced the medical benefits for employees with AIDS did not discriminate illegally).

exclusion of preexisting conditions in employer plans,<sup>41</sup> and required insurers to sell insurance to any employer who applied for group coverage.<sup>42</sup> Although making insurance more accessible and affordable for people in employer plans through these regulations, HIPAA did little for people who obtained insurance coverage on the individual market, perpetuating the regulatory variability between types of private coverage.

An obvious consequence of reserving private insurance regulation to states is that health insurance regulation also varies substantively by geography. For example, before the ACA, states had, on average, eighteen mandated benefits that insurers had to include in all policies they issued,<sup>43</sup> and the number of mandates varied from two in Idaho to thirty-five in California.<sup>44</sup> This story is the same for other types of health insurance regulation. Eighteen states have some kind of regulation that limits how much insurers can charge an individual who is buying a policy directly from an insurer<sup>45</sup> and twelve states subsidize such coverage for certain low-income individuals.<sup>46</sup>

The variability among types of insurance is further exacerbated by the Employee Retirement Income Security Act of 1974 (“ERISA”),<sup>47</sup> which prevents some state regulation from applying to some ESI plans. The law’s aim was to ensure that employers operating across multiple states could create consistent plans without having to comply with fifty different states’ laws.<sup>48</sup> ERISA preemption allows states to regulate any “fully-insured” plan, where an individual or employer buys a plan directly from an insurance company licensed in the state.<sup>49</sup> Yet, under ERISA, states cannot regulate so-called “self-funded” or “self-insured” plans, in which an

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41. § 1181.

42. 42 U.S.C. § 300gg-1 (2012) (modified by the ACA to apply to individual coverage as well).

43. See Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1364.

44. See *id.*

45. *Individual Market Rate Restrictions*, HENRY J. KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/individual-market-rate-restrictions/> (last visited Nov. 23, 2013).

46. *Health Insurance Subsidies in the Individual Market, as of January 2012*, HENRY J. KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/health-insurance-subsidies-individual-market/> (last visited Nov. 23, 2013).

47. Pub. L. No. 93-406, 88 Stat. 829 (codified at 29 U.S.C. §§ 1001–1461 (2012)).

48. See *id.*

49. 29 U.S.C. § 1144(a) (2012); see also GOSTIN & JACOBSON, *supra* note 11, at 334–35 (explaining ERISA preemption); HENRY J. KAISER FAMILY FOUND., *supra* note 33, at 16.



employer retains liability for claims, rather than transferring risk to an insurer.<sup>50</sup> Not surprisingly, many employers, including a majority of large employers, have chosen to self-insure and thus avoid state insurance regulation of their employee-health plans altogether.<sup>51</sup> The result of all of this fragmentation—structural and regulatory—is a complex web of health insurance that varies by market and by geography.

The ACA perpetuated and exacerbated this complexity. The ACA attempted to regulate the individual market, in particular, to ensure better access and affordability.<sup>52</sup> Secondary goals were to disrupt existing coverage as little as possible and to create a politically palatable reform plan.<sup>53</sup> To achieve these goals, the ACA preserved existing insurance market structures and perpetuated regulatory fragmentation to a large degree.<sup>54</sup> For example, while lawmakers could have created a more consistent set of regulations for all types of private insurance, they applied different rules to different insurance markets and chose to exempt self-insured plans from some of the ACA's substantive insurance regulations. The result is that employers who self-insure still retain great leeway over the design of their health plans.<sup>55</sup> The ACA added another level of fragmentation by "grandfathering" a number of health insurance plans that were in place before the ACA became law in 2010, exempting them from many of the ACA's requirements, at least in the short term.<sup>56</sup> The

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50. § 1144(a). Because most employers who self-insure obtain stop-loss policies, in reality, they retain limited risk.

51. See HENRY J. KAISER FAMILY FOUND. AND HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2013 ANNUAL SURVEY 158 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf> [hereinafter KFF & HRET ANNUAL SURVEY] (reporting 61% of covered workers were in a self-funded plan).

52. See *infra* Part II.B.1.

53. See, e.g., Barack Obama, Remarks by the President in Town Hall on Health Care, Grand Junction, Colo. (Aug. 15, 2009) (transcript available at [http://www.whitehouse.gov/the\\_press\\_office/Remarks-By-The-President-In-Town-Hall-On-Health-Care-Grand-Junction-Colorado/](http://www.whitehouse.gov/the_press_office/Remarks-By-The-President-In-Town-Hall-On-Health-Care-Grand-Junction-Colorado/)).

54. See Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 27, 27-30 (2011) (explaining inconsistent application of ACA regulations).

55. See *id.*

56. For example, the federally mandated "essential health benefits" and limits on out-of-pocket expenditures do not apply to grandfathered plans. ACA § 1251, 42 U.S.C. § 18011 (2012). A plan must remain substantially the same over time to enjoy this status, which will cause plans to slowly relinquish this status over time as economically necessary. Plans lose grandfathered status by making major changes, such as eliminating all or substantially all benefits to treat a particular condition, increasing coinsurance percentages, or decreasing employer contribution by more than five percentage points

result of the ACA's approach, layered over preexisting regulation, is the variable picture of financial protections for different insured populations examined below.

### *B. Regulation and Risk in Three Illustrative Scenarios*

For each of the three scenarios considered, this Section describes the type of coverage, outlines the relevant ACA regulations, and estimates maximum possible out-of-pocket spending for an individual with each type of insurance coverage. The discussion considers three types of out-of-pocket spending that can pose threats to financial security: (1) premiums; (2) cost sharing on covered benefits, and (3) spending on care not covered under a policy. If either the second or third type of variable spending is high or unlimited, an insured faces catastrophic spending risk. The tables below summarize possible out-of-pocket spending of each kind and, where possible, include ballpark estimates of total spending as a percentage of income.<sup>57</sup> Where there is significant unknown variable spending on cost sharing or uncovered benefits, the percentage estimates do not include this spending, but the tables note that it exists.

#### 1. Individual with Silver-Level Individual Coverage from an Exchange

One of the main goals of the ACA was to ensure that people who do not have insurance through their jobs could afford meaningful coverage. Before the ACA, this population was unquestionably the most vulnerable to financial insecurity due to health care spending. They struggled to get coverage at all and, because there were few limitations on how much insurers could charge them for coverage, the coverage they could get was often unaffordable.<sup>58</sup> After full ACA

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from the rate in place on March 23, 2010. Preservation of Right to Maintain Existing Coverage, 45 C.F.R. § 147.140 (2013). For a clear and concise summary of grandfathering, see Timothy Jost, *Implementing Health Reform: Grandfathered Plans*, HEALTH AFF. BLOG (June 15, 2010), <http://healthaffairs.org/blog/2010/06/15/implementing-health-reform-grandfathered-plans>.

57. The percentage of income estimates are based on median average income for an under age sixty-five household and an over age sixty-five household, and not tailored based on family size, gender, type of employment, and other characteristics. They are not meant as precise estimates, as might be possible through modeling, but rather are an attempt to give a ballpark sense of what a person with each type of coverage might spend on health care. See *supra* note 29.

58. See SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 4 (2006), available at [http://www.commonwealthfund.org/usr\\_doc/collins\\_squeezedrisinghlthcarecosts\\_953.pdf](http://www.commonwealthfund.org/usr_doc/collins_squeezedrisinghlthcarecosts_953.pdf).

implementation, an estimated twenty-six million people will buy a health insurance policy from a health insurance exchange, a new online marketplace established by the ACA.<sup>59</sup> The ACA regulates these policies extensively. As a result, the population buying an exchange plan is not only less financially vulnerable than they were before reform but also arguably less vulnerable in some ways than people with insurance through an employer or Medicare.

As illustrated below, the ACA preserves the potential for relatively high baseline costs but largely curbs catastrophic spending for someone who buys a silver-level exchange plan. Even in the worst case, the insured in this scenario would spend twenty to 30% of income out of pocket on health care.<sup>60</sup> While this amount is substantial, it may not mean financial disaster, especially if not recurrent over multiple years.

*a. Regulation of Exchange Coverage Under the ACA*

The ACA limits financial risk for someone who buys a plan on an individual market exchange in two ways. First, it attempts to ensure Americans will be able to get insurance with affordable premiums. Toward this goal, the ACA requires that insurers issue coverage to anyone who applies, thereby giving access to people who previously faced unlimited risk because they could not get insurance at all.<sup>61</sup> Once insured, the ACA attempts to limit the variation in premiums for similar coverage among these insured. It prohibits insurers from excluding any pre-existing conditions from coverage<sup>62</sup> and from “risk-rating” or charging someone more based on her individual characteristics or health history.<sup>63</sup> Premiums may still vary, but based on only four factors: family size, geography, tobacco use status, and age.<sup>64</sup> For example, premiums might vary by a factor of 3:1 based on age,<sup>65</sup> which means that a sixty year-old may be charged premiums no more than three times as high as a twenty-one year-old.

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59. CONG. BUDGET OFFICE, CBO’S FEBRUARY 2013 ESTIMATE OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE 1 (2013). A much smaller number of individuals will continue to buy individual market coverage directly from an insurer, where the regulations will still apply in many circumstances. *See id.*

60. If she uses services not covered by the policy, she might spend more, but the list of covered services is comprehensive and likelihood of using uncovered care reasonably low.

61. ACA § 1201, 42 U.S.C. § 300gg-1 (2012)) (adding § 2702 to the Public Health Service Act (“PHSA”)).

62. ACA § 1201, 42 U.S.C. § 300gg-3 (adding § 2704(a) to the PHSA).

63. ACA § 1201, 42 U.S.C. § 300gg-4 (adding § 2705 to the PHSA).

64. ACA § 1201, 42 U.S.C. § 300gg (adding § 2701 to the PHSA).

65. *Id.*

Also toward the goal of affordable premiums, the law includes mechanisms that reduce adverse selection, which occurs when healthy and sick people sort into different risk pools. When this occurs, the healthy people pay lower premiums because they enjoy lower health care spending per person in their risk pools. The unhealthy people suffer the opposite. To prevent this sorting and reduced interpersonal distribution, the law's "individual mandate" requires most Americans to maintain minimum essential coverage or else pay a penalty, thereby discouraging the healthy from opting out altogether.<sup>66</sup> Furthermore, the ACA requires that insurers who sell exchange policies must create a single pool for most individually insured in a state, reducing the likelihood of sorting by type of policy.<sup>67</sup> It also establishes risk adjustment and reinsurance mechanisms to level the playing field at the end of each year if some insurers do, in fact, attract more or less healthy individuals than others.<sup>68</sup> Through these regulations, the ACA attempts to reduce the variability of premiums among insured and, in turn, the chance that any one individual will be unable to afford insurance.

Another way the ACA attempts to keep premium rates low is by limiting insurer profit. Medical-loss ratio regulations require insurers in the individual market to spend 80% of premium dollars on medical care and health care quality improvement (as opposed to on administrative costs or profit).<sup>69</sup> The ACA also requires states to report on premium increases and gives them the opportunity to exclude particular insurers from the state exchanges if proposed rate increases in any year are considered too high.<sup>70</sup>

These mechanisms encourage but do not guarantee low premiums. If the individual mandate fails to encourage healthy people to buy coverage, adverse selection of less healthy people into the individual market overall might cause the average spending per

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66. ACA § 1501, 42 U.S.C. § 18091.

67. ACA § 1312, 42 U.S.C. § 18032(c)(1) (excluding members enrolled in grandfathered plans).

68. ACA §§ 1341–1343, 42 U.S.C. §§ 18061–18063.

69. ACA §§ 1001, 10101, 42 U.S.C. § 300gg-18(b)(1)(A); 45 C.F.R. § 158 (2013) (allowing the Secretary of DHHS to adjust this amount if necessary to stabilize the market).

70. 45 C.F.R. § 154. It does not, however, explicitly authorize prior approval over insurers' proposed rate increases (although some states have the authority to do so under state legislation). See *State Approval of Insurance Rate Increases*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/issues-research/health/health-insurance-rate-approval-disapproval.aspx> (last updated Feb. 2014) ("Over the past 25 years, about two dozen states gave the state insurance department or commission the legal power of prior approval, or disapproval, of certain types of rate changes.").

person and premiums to be high.<sup>71</sup> However, Massachusetts, which implemented a similar style reform in 2006, did not experience significant adverse selection problems in its individual market.<sup>72</sup> And experts predict that “rate shock” from adverse selection in the exchanges will likewise be limited.<sup>73</sup> Another possibility is that if too few insurance companies participate in the individual market exchanges, there will be insufficient competition to drive down premiums.<sup>74</sup> Or, ineffective state or federal rate review regulation might leave insurers unchecked in rate setting.<sup>75</sup> So far, the number of insurers participating in most states and year-one premium quotes suggest these problems are unlikely.<sup>76</sup>

The second major way the ACA attempts to lessen financial risk for individuals buying coverage on an exchange is to limit variable out-of-pocket spending. It does so by regulating cost sharing for covered benefits and by mandating certain benefits that plans must cover, thereby limiting spending on uncovered care. In terms of cost sharing, most simply, the ACA explicitly caps how much an insured will have to spend annually on a core set of “essential health benefits.”<sup>77</sup> This cap is \$6,350 for an individual or \$12,700 for a family in 2014, or less for lower-income insured.<sup>78</sup> The ACA also prohibits exchange plans from imposing annual or lifetime spending limits on these essential health benefits.<sup>79</sup> Previously, plans could impose these

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71. Some believe individual mandate penalties are not high enough to provoke young, healthy people to get coverage, which could undermine individual-market risk pooling.

72. See Amitabh Chandra et al., *The Importance of the Individual Mandate — Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293, 295 (2011).

73. See, e.g., LINDA J. BLUMBERG & JOHN HOLAHAN, ROBERT WOOD JOHNSON FOUND. & URBAN INST., HEALTH STATUS OF EXCHANGE ENROLLEES: PUTTING RATE SHOCK IN PERSPECTIVE 2, 7 (2013), available at <http://www.urban.org/UploadedPDF/412859-Health-Status-of-Exchange-Enrollees-Putting-Rate-Shock-in-Perspective.pdf> (concluding that the health profile of the exchange population will look similar overall to the population with employer-sponsored insurance, which is typically considered a good risk pool).

74. The theory of the exchanges is that insurers will try to offer the lowest premiums possible to attract customers by limiting operating costs and by negotiating the best rates with providers. However, if too few insurers participate in a particular state, monopolistic pricing could occur. Cf. James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, HEALTH AFF., Nov.–Dec. 2004, at 11 (describing consolidation in state insurance market and suppliers and effect on prices for medical care).

75. See *State Approval of Insurance Rate Increases*, *supra* note 70.

76. For a discussion of reported premium rates, see *infra* Section II.B.1.b.

77. ACA § 1302(c), 42 U.S.C. § 18022(c) (2012).

78. Rev. Proc. 2013-25, 2013-21 I.R.B. 1110. These amounts are adjusted annually for cost of living. I.R.C. § 223(c)(2)(A)(ii) (Supp. 2011).

79. ACA § 1001, 42 U.S.C. § 300gg-11(a).

types of limits on any benefit, where the plan would reimburse up to a set dollar amount of spending, after which the insured would have to pay completely out of pocket for continued use of that type of care.<sup>80</sup> For example, once the policy had paid for ten physical therapy visits or \$10,000 in mental health care in a year, the insured would have had to pay out of pocket for any additional visits or care.

A less straightforward approach to limiting cost sharing is the ACA's regulation of actuarial value. Actuarial value is the percentage of total health care spending on covered benefits that a plan reimburses for a pool of insured.<sup>81</sup> Plans sold on exchanges are categorized by "metal level" tiers that are defined by the actuarial value: platinum-level plans have 90% actuarial value, gold-level have 80%, silver-level plans have 70%, and bronze-level have 60%.<sup>82</sup> To illustrate, if one hundred people in a silver-level plan together spent \$1 million on medical care in 2014, the plan must pay for at least \$700,000 of these expenses to have an actuarial value of 70%. Because these percentages are calculated based on the total amount of spending for a group of insured people, any individual might pay a higher or lower percentage of her own medical expenditures, based on the particular care she uses and the policy's cost-sharing structure (but only up to the out-of-pocket limits discussed above). Yet, these levels curb the total combined deductibles, coinsurance, and copayments that any plan might impose, providing some—albeit imperfect—protection against high spending, even when using covered items and services.

Finally, the ACA requires that a plan's benefits cover most major medical needs, limiting an individual's variable out-of-pocket spending on uncovered services. For example, the ACA mandates plans cover certain preventive care without any cost sharing.<sup>83</sup> It also requires that "essential health benefits" be included in all non-grandfathered individual-market plans.<sup>84</sup> The Secretary of Health and Human Services has delegated the specific definition of what is "essential" to individual states,<sup>85</sup> which will mean that coverage will be somewhat variable state by state. But the law and regulations set a

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80. U.S. Dep't of Health & Human Servs., *Lifetime & Annual Limits*, HHS.GOV, <http://www.hhs.gov/healthcare/rights/limits/> (last visited Mar. 3, 2014).

81. ACA § 1302(d), 42 U.S.C. § 18022(d).

82. *Id.*

83. ACA § 1001, 42 U.S.C. § 300gg-13. Grandfathered plans are exempted. *Id.*

84. ACA § 1302, 42 U.S.C. § 18022.

85. 45 C.F.R. § 156.100 (2013); see also Robert Pear, *Health Care Law Will Let States Tailor Benefits*, N.Y. TIMES, Dec. 17, 2011, at A1 (reporting that the Obama administration gave "states the discretion to specify essential benefits").

high bar for what categories of care must be covered, including emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, and prescription drugs.<sup>86</sup> These essential health benefit requirements, combined with the actuarial value regulations discussed above, mean that policies will cover most critical medical needs reasonably comprehensively. Together, these new regulations significantly reduce the risk of catastrophic spending.

Finally, because even the level of spending that remains after these regulations might threaten the financial security of lower-income households, the ACA provides for premium and cost-sharing subsidies for anyone earning up to 400% of the federal poverty level (approximately \$46,000 for an individual) and without access to other, acceptable coverage, such as Medicaid, Medicare, or affordable insurance from their employer.<sup>87</sup> Premium tax credits are set on a sliding scale with the amount of subsidy decreasing as income increases.<sup>88</sup> In addition, an individual earning between 100% and 250% of the federal poverty level who buys silver-level coverage on an exchange is eligible for cost-sharing subsidies.<sup>89</sup> Through these measures, the ACA attempts to limit potential out-of-pocket

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86. ACA § 1302, 42 U.S.C. § 18022; 45 C.F.R. § 156.110.

87. ACA §§ 1401, 1402 (codified as amended at 26 I.R.C. § 36B (Supp. 2011), 42 U.S.C. § 18071). 400% of the federal poverty level is \$45,960 for an individual and \$94,200 for a family of four in 2013. *See* Annual Update of Health and Human Services Property Guidelines, 78 Fed. Reg. 5182 (Jan. 24, 2013).

88. An individual's contribution for exchange plan premiums is limited to 2% of income for someone earning 100% of the federal poverty level on a sliding scale to 9.5% of income for someone earning 300% to 400% of the federal poverty level. ACA § 1401(a) (codified as amended at 26 I.R.C. § 36B(b) (Supp. 2011)).

89. ACA § 1402(b)–(c), 42 U.S.C. § 18071(b)–(c). The cost-sharing limit for spending on essential health benefits is lower for anyone earning 100–250% of the federal poverty level. ACA § 1402(c), 42 U.S.C. § 1807(c); DEP'T OF HEALTH & HUMAN SERVS., Health and Human Services Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409, 15,482–83 (March 11, 2013) (using regulatory discretion to reduce eligibility for cost-sharing subsidies from the statutorily defined levels, limiting eligibility to those earning up to 250% of the federal poverty level instead of up to 400%, and reducing amount of cost sharing by one-fifth, instead of one-half, for anyone earning 200–250% of the federal poverty level). The ACA also provides additional federal subsidies to enable people earning 100–250% of the federal poverty level to enroll in plans with increased actuarial value to limit out-of-pocket spending (to 94% for someone earning 100–150% of the federal poverty level, to 87% for someone earning 150–200% of the federal poverty level, and to 73% for someone earning 200–250% of the federal poverty level). *Id.*; *see* HENRY J. KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES 2–3 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf>.

spending additionally for households with incomes below 400% of the federal poverty level.

*b. Projected Spending and Financial Risk*

These ACA regulations reshape individual market health insurance in ways that significantly diminish financial risk from health care spending. The following scenario considers how much an individual earning median household income who buys an average (silver-level) plan on an individual market exchange might spend annually on health care, even in a year of bad health.<sup>90</sup> It reveals that this individual remains vulnerable to high premiums and thus baseline spending could cause financial strain. But her variable costs will be limited and catastrophic risk largely eliminated.

Early projections and studies of 2014 reported premium rates indicate the likely cost of coverage and the variability of such premiums across states and age groups.<sup>91</sup> The RAND Corporation projected that over the next few years, premiums in the individual market might decline as a result of the ACA.<sup>92</sup> They estimate the weighted-average premium for an individual will be just over \$3,000 in 2016, when accounting for subsidies.<sup>93</sup>

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90. The median household income is based on a household under age sixty-five, not for one with specific demographic attributes. See discussion *supra* note 29. Although the author used feminine pronouns throughout for narrative simplicity, the estimates below are based on an average member of the insured group, not tailored based on gender.

91. See, e.g., AVALERE HEALTH, AVALERE ANALYSIS OF EXCHANGES RATES FOR 2014, at 2 (2013); DEP'T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE PREMIUMS FOR 2014, at 13–14 (2013); CHRISTINE EIBNER ET AL., RAND CORP., THE AFFORDABLE CARE ACT AND HEALTH INSURANCE MARKETS: SIMULATING THE EFFECTS OF REGULATION 35–36 (2013).

92. EIBNER ET AL., *supra* note 91. This study, undertaken for the Department of Health and Human Services to estimate individual market premiums under a number of conditions, uses data from the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer Benefits. The researchers use a “utility maximization approach,” assuming (likely overly optimistically) that families will choose a plan that maximizes their utility. *Id.* at 6–7. They also assume that individual mandates are perfectly enforced and that states will expand their Medicaid programs. *Id.* at 16, 20.

93. *Id.* at 23, 45. The total estimated premium is nearly \$5,000, when including federal tax credits. *Id.* at 46. Actual premiums reported so far appear to be somewhat lower than the RAND estimates. RAND attributes this discrepancy to the fact that reported premiums are for 2014 and their estimates are for 2016, as well as a number of other factors, including potential gaming by insurers to set prices low at first to gain market share and that the data on nongroup premiums prior to the ACA, on which they base their analysis, are limited. *Id.* at 16–18.



Reported actual rates for 2014 are roughly in accord with the RAND projections. A study by Avalere Health estimates an average annual silver-level plan premium of just over \$4,000 annually (\$336 per month).<sup>94</sup> Many enrollees are estimated to qualify for premium subsidies that will pay for part of this amount.<sup>95</sup> A Department of Health and Human Services study, which examines the thirty-six states with federally run or supported exchanges, reported a similar weighted average across these states.<sup>96</sup> Based on these estimates, premiums would consume on average about 7% of the median household income or 11% of adjusted gross income.

The Avalere study also illustrates the effects of age-rating bands (i.e., the allowed variation of premiums by age<sup>97</sup>) by separately reporting average silver-level plan premiums for twenty-one, forty, and sixty year-olds. For the twenty-one year-old, the average annual premium is \$3,252.<sup>98</sup> For a forty year-old, the average is \$3,924 annually.<sup>99</sup> For a sixty year-old, the average premium is considerably higher: \$7,380 annually, with premiums as high as \$9,168 annually in Connecticut.<sup>100</sup> In the worst-case reported, a sixty year-old in Connecticut could spend as much as 16% of median household income (26% of adjusted gross income) on premiums.

Variable out-of-pocket cost sharing is more limited under the ACA regulations than before, but could still be substantial for some people who experience a year of bad health. With respect to cost sharing for covered services, the ACA limits an individual's spending to \$6,350.<sup>101</sup> Most people will not reach this maximum. In fact, to spend this much with a silver-level plan, someone will have to have

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94. AVALERE HEALTH, *supra* note 91, at 3 (examining public rate filings released in twelve states, eight with state-run and four with federally run exchanges, including California, Connecticut, the District of Columbia, Indiana, Maryland, New York, Ohio, Rhode Island, South Dakota, Vermont, Virginia, and Washington). The bronze-level plan estimate is \$3,288, or \$274 per month. *Id.*

95. *Id.* at 1.

96. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 91, at 13–14 (reporting the weighted average premiums in forty-eight states to be \$328 per month in the second-lowest cost silver plan (\$3,936 annually)). For a twenty-seven year-old buying the second-cheapest silver-level plan, this study estimates premiums to be \$214 on average, ranging from \$161 in Tennessee to \$342 in Wyoming. *Id.* at 8.

97. See *supra* note 64–65 and accompanying text.

98. AVALERE HEALTH, *supra* note 91, at 2.

99. *Id.* These premiums vary geographically; for example, in New York the average premium for a forty year-old is \$5,328 annually, because age rating is prohibited and younger enrollees thus subsidize older ones. *Id.*

100. *Id.* Avalere reports a low premium of \$411 per month (\$4,932 annually) in Vermont, where age rating is prohibited so that older enrollees do not pay more. *Id.*

101. See *supra* note 78 and accompanying text.

consumed enough medical care over the year to be in the top third of overall health care spenders.<sup>102</sup>

One study estimated that if the ACA had been in place in between 2001 and 2008, average annual out-of-pocket cost sharing would have been \$280 less, with fifty-five to sixty-four year-olds saving nearly \$600 on average per year.<sup>103</sup> Perhaps more importantly, the ACA would have significantly reduced the threat of annual cost sharing greater than \$4,000 for lower-income families,<sup>104</sup> and would have reduced by three-quarters the likelihood of expenditures over \$6,000 for anyone.<sup>105</sup> As a result of its regulations, the ACA will thus reduce variable spending for the typical spender and minimize catastrophic risk for most households.

Table 1 summarizes the picture of baseline and variable spending in this scenario, illustrating the maximum amount a forty year-old and sixty year-old who buy a silver-level policy on the exchange might have to spend out of pocket, in a year of relatively poor health. As illustrated in the first row, a forty year-old with average premiums could spend over \$10,000 in a year, which is nearly 18% of median household income or nearly 30% of median adjusted gross income.<sup>106</sup>

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102. With actuarial value of 70%, enrollees pay only 30% of total costs on average for a group of insured. If an individual pays about the average share of total costs experienced among enrollees in a silver-level plan, she will have to have incurred \$21,000 total in medical care spending over the year for her own out-of-pocket share to be \$6,350 (30% of \$21,165). Models suggest a relatively high deductible silver-level plan might have a \$4,200 deductible and 20% coinsurance. HENRY J. KAISER FAMILY FOUND., WHAT THE ACTUARIAL VALUES IN THE AFFORDABLE CARE ACT MEAN 4 (2011) (modeling possible cost-sharing designs with different metal levels). This plan would still require nearly \$15,000 in total spending to incur \$6,350 in cost sharing (the first \$4,200 plus 20% of the next \$10,750). \$15,000 per year in expenditures still puts the individual into the top one-third of individual spenders. NAT'L INST. FOR HEALTH CARE MGMT., *supra* note 9, at 3 (citing that the top 30% spent \$12,265 in 2009 which, with 4% growth per year, would be \$14,922 in 2014 (4% is the approximate average annual level of projected health care cost growth for 2009-2014. CTRS. FOR MEDICARE AND MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2011-2021, at 1 (2011)).

103. See Steven C. Hill, *Individual Insurance Benefits to Be Available Under Health Reform Would Have Cut Out-of-Pocket Spending in 2001-08*, 31 HEALTH AFF. 1349, 1349, 1354 (2012).

104. See *id.* at 1354 (defining lower-income as under 400% of the federal poverty level).

105. See *id.* (reducing incidence from 2.6% of all adults with individual coverage to 0.6% but not eliminating the possibility because of out-of network charges and uncovered services).

106. These percentages are a rough estimate and might be somewhat higher or lower depending on individual characteristics of exchange enrollees. See discussion *supra* notes 29 and 57. For example, if an individual lives in New York, the state with highest reported premiums for a forty year-old, her total spending on covered items could be \$11,678

She could also incur some, although likely limited, spending on items or services not covered by her policy (and thus not mandated as essential health benefits) or on services provided by doctors out of her network. This type of spending on uncovered benefits is less likely in exchange plans than in other plans because of the essential health benefit coverage requirements.

A sixty year-old could spend more. Even with average premiums (\$7,380), she could spend a quarter of median household income on out-of-pocket health care costs. Living in a state like Connecticut with relatively high premiums, she might spend even more (\$9,168 in premiums and \$6,350 in cost sharing). But even in this worst-case scenario with high baseline costs and high health care utilization, total spending is not unlimited, thus minimizing catastrophic risk to some degree.

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(\$5,328 in average premiums for a forty year-old in New York plus \$6,350 in cost sharing). AVALERE HEALTH, *supra* note 91, at 1, 2.

**Table 1. Maximum Out-of-Pocket (OOP) Spending in Scenario Considering Person with Average Silver Coverage from Individual Market Exchange (forty and sixty year-old)**

	Determinants of OOP Spending			Total Possible OOP Spending**	Max. Perc. of Income***
	Average Annual Premium*	Cost Sharing	Uncovered Care		
<i>Forty year-old</i>	\$3,924	\$6,350 limit on Essential Health Benefits	Plans must cover: Essential Health Benefits	\$10,274	18%
<i>Sixty year-old</i>	\$7,380		Preventive Health Services with no cost sharing  •Low risk of spending on uncovered care	\$13,730	24%

\* Source: Avalere Health LLC Analysis of Exchanges Rates for 2014 (2013).

\*\* Estimates exclude spending on uncovered items and services, which are relatively low in this scenario because of the mandated coverage of essential health benefits.

\*\*\* Percentage estimates are based on the median household income for those under age sixty-five.

This scenario illustrates the top possible spending for an individual with average silver-level exchange coverage because it assumes the insured earns too much to be eligible for premiums and cost-sharing subsidies. Income above 400% of the federal poverty level completely disqualifies someone from subsidies.<sup>107</sup> If the insured were the matriarch of a family of four, median household income would be just under 250% of the federal poverty level, which would qualify the family for premium credits and cost-sharing subsidies.<sup>108</sup>

107. In response, people with income just above this level might attempt to reduce earnings, if possible, to qualify for subsidies.

108. These examples assume her employer did not offer coverage that is considered “affordable” (premiums less than 9.5% of income) and “minimum value” (actuarial value

They would pay no more than about 8% of income, or approximately \$4,500 per year, on premiums for all four people, according to the ACA's sliding scale.<sup>109</sup> In addition, cost sharing for the family would be reduced to 80% of the family limits discussed above (just over \$10,000).<sup>110</sup>

These examples illustrate that the ACA has attempted to increase financial security for people buying coverage on an exchange by limiting the tail of spending exposure and thus catastrophic risk. This policy vision of financial security is one where an individual might still incur significant health care spending over the course of a year on premiums and cost sharing, especially if in bad health, but, even in the worst case, will not face unbounded spending on essential care.<sup>111</sup> Thus, the ACA's working regulatory definition of financial security for this group is one of low catastrophic risk.

## 2. Worker with Employer-Sponsored Insurance Coverage

Although the ACA revamps the individual insurance market, it preserves much of ESI as is. About 165 million individuals will likely have coverage through an employer after full implementation of the ACA, up slightly from current numbers.<sup>112</sup> Most of these insured employees will be in an employer "self-funded" plan.<sup>113</sup> This Section considers a scenario with a person earning a median household income and working for a large employer with such a self-funded plan.<sup>114</sup>

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of at least 60%), which would disqualify her for subsidies. ACA § 1401(a) (codified as amended at 26 I.R.C. § 36B(c)(2)(C) (Supp. 2011)).

109. ACA § 1401(a) (codified as amended at 26 I.R.C. § 36B(b)) (showing contribution of 8.05% for someone earning 250% of the federal poverty level).

110. ACA § 1402(c)(1)(A)(ii), 42 U.S.C. 18071(c)(1)(A) (2012); DEP'T OF HEALTH & HUMAN SERVS., Health and Human Services Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409, 15,482–83 (Mar. 11, 2013) (reducing cost sharing by one-fifth for someone earning between 200–250% of the federal poverty level).

111. The potential for unbounded spending still exists when using care that is not considered an "essential health benefit" or is not covered under the plan.

112. See CONG. BUDGET OFFICE, *supra* note 59, at 1 (predicting that in 2019, 165 million Americans will receive health insurance from an employer, compared to 154 million Americans who received health insurance from an employer in 2013).

113. See *id.*

114. As noted above, median income for such an individual is likely to be somewhat higher than for an individual in an exchange plan. But this analysis uses overall median household income in both scenarios because the income of exchange enrollees is not yet known. See *supra* note 29.

People with ESI have historically been more sheltered than other insured from financial risk caused by health care spending.<sup>115</sup> Going forward, however, their continued protection is not guaranteed. This effect flows from a central feature of the ACA: it perpetuates a pre-ACA practice of deference to employers with respect to the terms of their benefits for employees, as discussed above with regard to ERISA preemption.<sup>116</sup> That is, rather than prescribing how health insurance should promote financial security for people with ESI, the ACA inserts a placeholder for an employer's definition. Some trends suggest that ESI is already becoming less comprehensive, due to increased cost sharing and the growing adoption of high deductible health plans and more limited networks of providers.<sup>117</sup> For these reasons and because ESI plans are subject to few mandated benefits, employees could find themselves subject to especially high spending on uncovered benefits.

*a. Regulation of Employer-Sponsored Insurance Under the ACA*

Many of the ACA financial security regulations do not apply to large-group ESI for both practical and political reasons.<sup>118</sup> Practically, employer plans have historically offered fairly solid coverage, protecting employees well from high out-of-pocket spending. Large employers have been able to exert bargaining power against insurers, which has kept prices low. Employer plans have also provided beneficiaries relatively comprehensive benefits, limiting insureds' spending on uncovered goods and services.<sup>119</sup> In fact, the ACA directs the Secretary of Health and Human Services to model the essential health benefits for exchange plans after coverage in employer plans.<sup>120</sup> Large workplaces generally create good risk pools with both healthy and sick people so that the average cost per person is stable (and, as noted above, under HIPAA, employers are not permitted to treat employees differently or charge them more based on individual

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115. See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001) (concluding that the employment-based coverage model functions well).

116. See *supra* notes 47–51 and accompanying text.

117. See KFF & HRET ANNUAL SURVEY, *supra* note 51, at 65 (showing increase in enrollment by covered workers in high-deductible health plans from 1999 until 2013).

118. See Jost, *supra* note 54, at 28–29.

119. *Id.* at 58; see also Hyman & Hall, *supra* note 115, at 31 (explaining that employer-based coverage is more comprehensive, enabled by substantial tax subsidies).

120. ACA § 1302(b)(2), 42 U.S.C. § 18022 (2012.).

health status<sup>121</sup>). Finally, employers have typically paid a large part of the premium costs for employees' plans,<sup>122</sup> resulting in low employee out-of-pocket premium contributions.<sup>123</sup>

Politically, it was more feasible to pass legislation that was amenable to the business community lobby. Thus, deference to employers was likely critical to the ACA's passage.

For these reasons, the ACA leaves employer plans exempt from many ACA regulations, banking perhaps on the assumption that employers will continue to offer relatively comprehensive coverage. Most importantly, the essential health benefit requirements do not apply to large-group or self-funded plans.<sup>124</sup> This means that if employers decide not to cover commonly used or expensive items or services, employees will face high out-of-pocket spending for uncovered care.

Yet, some new financial protections to limit variable spending do extend into this mostly unregulated space, evincing that these protections were deemed a crucial part of the ACA's regulations for all insured and thus worth the political battle. Most importantly, the ACA extends out-of-pocket spending limits and the prohibition of annual coverage limits on essential health benefits to all plans,<sup>125</sup> including self-funded plans.<sup>126</sup> Most plans cover these benefits and will now have to offer them on these new terms or, alternatively, discontinue offering them. In addition, all plans, apart from grandfathered plans, are required to cover preventive health services without cost sharing.<sup>127</sup>

The ACA generally provides no subsidies to low-income individuals for premiums or cost sharing in employer plans. But, if an employer's plan is either not "affordable" (premiums exceed 9.5% of income) or does not provide "minimum value" (actuarial value of at least 6%), a lower-income employee can buy subsidized coverage on

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121. 29 U.S.C. § 1182 (2012) (forbidding "discrimination against individual participants and beneficiaries based on health status").

122. See KFF & HRET ANNUAL SURVEY, *supra* note 51, at 70 (reporting premium contributions by workers on average are eighteen to 20% of total premium costs, the rest of which is paid for by the employer).

123. *Id.*

124. ACA § 1201, 42 U.S.C. § 300gg-6; ACA § 1301, 42 U.S.C. § 18021.

125. ACA § 1302(c), 42 U.S.C. § 18022(c); DEP'T OF HEALTH & HUMAN SERVS., Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule, 78 Fed. Reg. 12,834, 12,837 (2013) (interpreting the out-of-pocket maximums as applying to all non-grandfathered plans).

126. ACA § 1001, 42 U.S.C. § 300gg-11(a).

127. ACA § 1001, 42 U.S.C. § 300gg-13.

the individual-market exchanges.<sup>128</sup> So, for lower-income employees, there is an escape hatch from limited employer plans, and premiums are effectively limited to 9.5% of income. Higher-income employees could also choose to buy exchange plans, but they would not receive subsidies. Plus, they would lose the value of the employer's contribution toward their health care benefits and the preferential tax treatment of their own contributions, which can be financed with pre-tax dollars. Thus, an employer plan would have to be especially low-value for a higher-income employee to opt out.

*b. Projected Spending and Financial Risk*

Baseline out-of-pocket spending on premiums is low for most people with ESI. Average annual premiums for ESI in 2013 were \$5,884 for single coverage and \$16,351 for family coverage,<sup>129</sup> but most of this spending is invisible to the workers. An employee pays on average only \$1,065 annually for single coverage in a large-group health plan.<sup>130</sup> Only about one-quarter pays \$1,400 or more per year for premiums,<sup>131</sup> amounts far from "unaffordable" under the terms of the ACA.

Looking at premiums this way, however, is somewhat misleading. The employer subsidizes the difference between the employee contribution and the actual cost of coverage. Health insurance premiums comprise a high and increasing share of total employee compensation and are blamed as a cause of wage stagnation and, in recent years, a decline in real median household income.<sup>132</sup> Thus, the median income earner might earn higher wages if her employer were not paying for her health insurance; she would also pay more for health insurance coverage. This analysis considers the employee's share of spending and current household median income in a static state. This approach offers a realistic snapshot of the current lived experience for an employee, but somewhat underestimates the effect of health care costs on disposable income. Based on these

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128. ACA § 1401(a) (codified as amended at I.R.C. § 36B(c)(2)(C) (Supp. 2011)) (defining a lower-income employee as one with income under 400% of the federal poverty level).

129. KFF & HRET ANNUAL SURVEY, *supra* note 51, at 20. These relatively high premiums are indicative of the typical comprehensiveness of benefits and coverage.

130. *Id.* at 77.

131. *Id.* at 84.

132. See, e.g., Uwe E. Reinhardt, *The Central Challenge in U.S. Health Policy*, N.Y. TIMES ECONOMIX BLOG, at fig.5 (Aug. 30, 2013, 12:01 AM), [http://economix.blogs.nytimes.com/2013/08/30/the-central-challenge-in-u-s-health-policy/?emc=edit\\_tnt\\_20130830&intemail0=y&\\_r=1](http://economix.blogs.nytimes.com/2013/08/30/the-central-challenge-in-u-s-health-policy/?emc=edit_tnt_20130830&intemail0=y&_r=1) (showing a fall in real median income since 2008).



assumptions, a typical employee with median household income pays a relatively small part of her take-home pay for health insurance coverage.

Out-of-pocket cost sharing on covered benefits is also relatively low, as compared to other forms of health insurance. Most employees have a plan with a deductible, which they must pay out of pocket before coverage begins.<sup>133</sup> The average deductible is \$884 in large-firm plans; only 8% of people in large-firm ESI have a deductible of \$2,000 or more.<sup>134</sup> In addition to the ACA's limits on cost sharing on essential health benefits, most plans include their own annual cost-sharing maximums on all plan benefits, many of which are even lower than the ACA limits.<sup>135</sup>

Nevertheless, some workers still face potentially high cost sharing. For example, one study shows that people with chronic diseases face higher spending in ESI plans because they use more prescription drugs and pay a higher percentage of the cost of these drugs than they would for other benefits.<sup>136</sup> Some plans do not count spending on prescription drugs toward cost-sharing maximums.<sup>137</sup> Further, about one-quarter of workers with single coverage have a cost-sharing limit over \$5,000 or none at all.<sup>138</sup> With no limit, someone might spend an uncapped amount on cost sharing for benefits that are covered by their plan but are not essential health benefits, for which the ACA limits do not apply. For example, an employer plan might include expensive fertility treatment but only cover up to \$10,000 on this treatment in a year. Because this treatment is not an essential health benefit subject to ACA regulations, the employer fully dictates the extent of coverage and the insured worker will have to pay all of the costs of fertility treatment after the first \$10,000. To be sure, this feature of the ESI plans does not make employees any worse off than exchange enrollees, for whom the ACA's cost-sharing limits likewise only apply to essential health benefits. But a worker in an ESI plan

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133. KFF & HRET ANNUAL SURVEY, *supra* note 51, at 105.

134. *Id.* at 107, 109. Fifteen percent of workers with ESI over all have a deductible of \$2,000 or more. *Id.* at 109.

135. *Id.* at 126–27 (reporting that nearly 80% of single coverage plans with an out-of-pocket maximum have limits of \$3,000 per year or less, less than half of the ACA limits).

136. See Jean M. Abraham et al., *Gauging the Generosity of Employer-Sponsored Insurance: Differences Between Households with and Without a Chronic Condition* (NBER Working Paper No. 17232, 2011) (finding that the chronically ill have “less generous insurance” than those who are not chronically ill).

137. KFF & HRET ANNUAL SURVEY, *supra* note 51, at 102.

138. *Id.* at 126–27 (reporting 12% have no maximum, 8% have a maximum between \$5,000 and \$5,999 and 4% have a maximum of \$6,000 or more).

might be more likely to start expensive treatment regimens that are initially covered by their generous policies, only to later discover the limitation in the policy's coverage, unless the policy's terms of coverage are transparent.

Where employees in employer plans are potentially worse off, however, is with regard to catastrophic spending risk: their plans are not required to cover essential health benefits at all, increasing their potential of needing care that is not covered by the plan. In fact, the ACA creates an incentive for employers *not* to cover these essential health benefits, by requiring that to the extent they do cover them, they may not impose annual and lifetime caps and must adhere to the out-of-pocket spending limits under the ACA.<sup>139</sup> At a time when employers are scaling back coverage, these requirements might make covering these benefits too expensive. For uncovered benefits, the insured must pay completely out of pocket for use of services and items with no limit at all to spending. For example, the ACA includes prescription drugs as an essential health benefit.<sup>140</sup> An employer might choose to exclude prescription drug coverage from its ESI plan altogether, leaving the employee to pay for all prescription drugs costs out of pocket.

Table 2 maps an illustrative scenario of what an employee with a median household income and average employer coverage could spend out of pocket in a year of bad health. As discussed above, the likely premiums are low compared to exchange plans, and the cost-sharing limits are similar with regard to essential health benefits, although potentially high with regard to non-essential ones. This means that total spending on premiums and "essential" covered benefits is lower than for exchange enrollees (approximately 13% of income or just over 20% of adjusted gross income). The main difference is that without mandated coverage of essential health benefits, an employee could be exposed to significant financial risk if her employer chooses not to cover commonly used or expensive categories of necessary care.

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139. ACA § 1302(c), 42 U.S.C. § 18022(c) (2012.); DEP'T OF HEALTH & HUMAN SERVS., Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule, 78 Fed. Reg. 12,834, 12,837 (Feb 25., 2013) (interpreting the out-of-pocket maximums as applying to all non-grandfathered plans).

140. ACA § 1302, 42 U.S.C. § 18022.

**Table 2: Maximum Out-of-Pocket (OOP) Spending in Scenario Considering Worker with Average Employee Coverage**

	Determinants of OOP Spending			Total Possible OOP Spending	Maximum Percentage of Income**
	Average Annual Premium*	Cost Sharing	Uncovered Care		
<b>Employee with Single Coverage</b>	\$1,065	\$6,350 limit on Essential Health Benefits, if covered	Plans must cover:  Preventive Health Services with no cost sharing  Not required to cover Essential Health Benefits • <i>risk of spending on uncovered essential care</i>	\$7,415 + <b>unlimited spending on uncovered care</b>	13% + <b>unlimited spending on uncovered care</b>
* Based on costs of top quarter of plans in KFF & HRET 2013 Annual Survey and on employee share of premium costs. Could be considerably higher if employer does not subsidize premiums.					
** Percentage estimates are based on the median household income for those under age sixty-five.					

The situation could be worse if the insured is the sole breadwinner for a family of four. In contrast to the family with the exchange plan discussed above, larger family size does not reduce financial insecurity.<sup>141</sup> ESI premiums are typically higher for family coverage than for individual coverage.<sup>142</sup> But the Internal Revenue Service concluded it will look only at the premium cost for an individual employee plan, not at the higher cost of coverage for a family, to determine if premiums exceed the “affordability” threshold of 9.5% of income triggering eligibility for exchange subsidies.<sup>143</sup> This means that if an employee can buy a policy for herself that costs 7%

141. This reality is arguably due to misinterpretation of the ACA rule allowing a person access to exchange subsidies if employer coverage premiums are “unaffordable,” or exceed 9.5% of income. ACA § 1401(a), 26 I.R.C. § 36B(c)(2)(C) (2012).

142. Even though higher, the premiums typically rise at a rate less than linear with family size, which means that individual employees in effect subsidize employees with families in the risk pool.

143. Treas. Reg. § 1.36B-2(c) (2013).

of her income but one for her whole family would cost 15% of her income, the IRS considers the policy affordable. Over one-third of all workers pay premiums that would be “unaffordable” for a family with median household income if family premiums were considered.<sup>144</sup>

These examples illustrate that the ACA has attempted to preserve the current structure of ESI to a large degree, in line with earlier health insurance policy. The law extends limits on cost sharing for essential health benefits to employer coverage, but renders these limits a paper tiger without also mandating coverage of these essential benefits. Thus, the ACA’s working regulatory definition of financial security for this group varies based on what an employer decides to cover in its employee plan. Based on the current state of ESI, the definition is typically one of low baseline spending, low variable spending, and low catastrophic risk. In effect, ESI is now the most protective form of insurance among those examined here, but its protections are not guaranteed going forward.

### 3. Retiree with Medicare and Medigap

Over sixty million individuals are expected to have Medicare coverage after full ACA implementation,<sup>145</sup> most of whom will be over the age of sixty-five.<sup>146</sup> Considering how the ACA will affect members of this last group is especially complex because of the variability in Medicare coverage and the fact that most people have supplemental coverage. The first scenario below briefly considers a retiree with Original, or “fee-for-service,” Medicare coverage, plus Medicare drug coverage. The second scenario considers the same individual also with “Medigap,” a private insurance plan for supplemental medical coverage. This second scenario, with supplemental coverage, is more illustrative of the financial risk faced by most retirees and is the primary focus of this analysis.

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144. KFF & HRET ANNUAL SURVEY, *supra* note 51, at 84 (estimating 9% pay between \$5,497 and \$6,392 per year and 21% pay \$6,392 per year or more for family coverage).

145. THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, 2013 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 198 (2013) [hereinafter BDS. OF TRS. 2013 ANNUAL REPORT] (estimating 64,272,000 individuals will be covered by Part A Hospital Insurance and/or Part B or D Supplemental Medical Insurance in 2020).

146. These estimates assume the eligibility age does not increase. A minority of Medicare enrollees are disabled individuals under age sixty-five. In 2012, of 50.7 million Medicare beneficiaries, 42.1 million were over age sixty-five and 8.5 million were disabled. *Id.* at 6.

The analysis reveals two regulatory conceptions of financial security protection for retirees, envisioned by Medicare and reinforced by the ACA. The first, for someone with only Original Medicare, involves low baseline spending but a high potential for variable spending and uncapped catastrophic risk due to high cost sharing. In response to this high cost sharing and probably equally to confusion caused by the opacity of Medicare coverage, 90% of retirees obtain supplemental coverage to fill in the gaps.<sup>147</sup> By buying supplemental coverage, retirees choose a definition of financial security based on higher baseline costs in return for low potential variable spending and catastrophic risk. Retirees thus must choose between high catastrophic risk or high baseline spending, and most opt for the latter.

Medicare finances about one-half of total health care costs for enrollees through an array of different programs that have been pieced together over time.<sup>148</sup> Original Medicare is comprised of two parts: Part A, which pays mostly for hospital and inpatient care, and Part B Supplementary Medical Insurance, which pays primarily for outpatient care.<sup>149</sup> For most people, enrollment in Part A is automatic and free.<sup>150</sup> Part B enrollment costs start at \$104.90 per month for anyone earning \$85,000 or less and increase on a sliding scale.<sup>151</sup> Both of these parts of Original Medicare have high and unlimited out-of-pocket cost sharing. For example, beneficiaries pay a deductible for a hospital stay of \$1,216 for the first 60 days.<sup>152</sup> For longer stays, beneficiaries must pay \$304 *per day* for days 61 to 90, \$608 *per day* for days 91 to 150, and all costs after 150 days.<sup>153</sup> For outpatient care, beneficiaries pay a 20% coinsurance rate for most services.<sup>154</sup>

Low-income subsidies for Medicare enrollees are much more limited than for exchange enrollees. Enrollees earning below 135% of

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147. See JULIETTE CUBANSKI ET AL., HENRY J. KAISER FAMILY FOUND., MEDICARE CHARTBOOK 60 (4th ed. 2010), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8103.pdf> (reporting that Medicare finances 48% of total costs of health care for Medicare fee-for-service beneficiaries).

148. See *id.* at 70.

149. *Id.* at 20.

150. *Id.* at 22. Part A is premium-free if an individual or spouse worked forty or more quarters of Medicare-covered employment where they contributed Medicare payroll taxes. *Medicare Part A*, EXTENDHEALTH.COM, <https://www.extendhealth.com/medicare/part-a> (last visited Nov. 23, 2013).

151. *Medicare 2013 & 2014 Costs at a Glance*, MEDICARE.GOV, <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html> (last visited Jan. 28, 2014).

152. *Id.*

153. *Id.*

154. *Id.*

the federal poverty level are dually eligible for Medicaid, which subsidizes their Medicare premiums and cost sharing.<sup>155</sup> This eligibility level is just under \$16,000 for an individual and about \$21,500 for a couple.<sup>156</sup> In addition, an enrollee must have extremely low asset levels,<sup>157</sup> which means those who qualify are already in a tenuous financial position.

Ninety percent of retirees obtain supplemental medical coverage to fill in Medicare coverage gaps.<sup>158</sup> For about one-fifth of retirees, this coverage is through a Medigap private supplemental plan.<sup>159</sup> Those with Medigap pay higher premiums than retirees with other forms of supplemental coverage but they face little variable spending and catastrophic risk.<sup>160</sup> This means that considering Medigap in the scenario below slightly overestimates premiums and underestimates the potential for variable spending as compared to other types of supplemental plans, such as retiree coverage through an employer.

Medigap plans are highly regulated private insurance plans with standardized terms that differ by plan types, identified by letter (A–N).<sup>161</sup> Federal regulation determines what a plan must cover to be classified and sold as each letter type.<sup>162</sup> Nearly one-half of all Medigap enrollees choose the most popular plan (“Plan F”),<sup>163</sup> which entirely covers Medicare Parts A and B cost sharing.<sup>164</sup> Even though

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155. *Seniors & Medicare and Medicaid Enrollees*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html> (last visited Nov. 23, 2013).

156. *Id.* (reporting a monthly income of \$1,333 for an individual and \$1,790 for a couple for the Qualifying Individual program, which has the highest levels of eligibility for Medicaid dual-eligibility subsidies).

157. *Id.* (reporting asset limits of \$7,160 per individual and \$10,750 per couple to qualify).

158. CUBANSKI ET AL., *supra* note 147, at 60.

159. *Id.*

160. Those with Medigap supplemental coverage face the greatest total out-of-pocket exposure among all retirees, even more than those with no supplemental coverage, who are spared premium costs and may consume less care than people with supplemental coverage do. See Dana P. Goldman & Julie M. Zissimopoulos, *High Out-of-Pocket Health Care Spending by the Elderly*, 32 HEALTH AFF. 194, 198 (2013).

161. ASSISTANT SEC’Y FOR PLANNING & EVALUATION OFFICE OF HEALTH POLICY, DEP’T OF HEALTH & HUMAN SERVS., ASPE REPORT: VARIATION AND TRENDS IN MEDIGAP PREMIUMS 6 (2011).

162. *Id.*

163. AM.’S HEALTH INS. PLANS, MEDIGAP: WHAT YOU NEED TO KNOW 3 fig.3 (2011), [www.ahip.org/MedigapWhatYouNeedtoKnow/](http://www.ahip.org/MedigapWhatYouNeedtoKnow/) (reporting 45% of beneficiaries enrolled in Plan F and 17% enrolled in Plan C, which is similar to plan F, in 2009).

164. See KATHRYN LINEHAN, NAT’L HEALTH POLICY FORUM, ISSUE BRIEF NO. 845, RECENT PROPOSALS TO LIMIT MEDIGAP COVERAGE AND MODIFY MEDICARE COST

some plans are not as comprehensive, most cover a majority of the cost sharing.<sup>165</sup> Medigap Plan F had average monthly premiums of \$171 in 2010.<sup>166</sup> If premium growth rates remained constant from the decade prior,<sup>167</sup> the 2014 premiums would be just over \$200. The estimates in Table 3B below are based on this premium estimate, but spending might be somewhat lower or higher based on plan type, geography, or individual characteristics.<sup>168</sup>

Ninety percent of Medicare enrollees also have prescription drug coverage,<sup>169</sup> mostly through the Medicare Part D prescription drug benefit.<sup>170</sup> The average weighted monthly Part D plan premium was projected at just over \$40 in 2013.<sup>171</sup> About 40% of all Part D enrollees, who have incomes below 150% of the federal poverty level and very low assets, receive additional federal assistance with premiums.<sup>172</sup> Cost sharing in Part D has been significant but is decreasing under the ACA, as discussed below.

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SHARING 5 (2012). Some Plan F beneficiaries opt for a “high deductible” option where they pay the first \$2,000 in expenditures after which the Medigap plan covers all costs. *Id.*

165. ASSISTANT SEC’Y FOR PLANNING & EVALUATION OFFICE OF HEALTH POLICY, *supra* note 161, at 7 (showing coverage by plan type).

166. *Id.* at 4 (reporting enrollment-weighted premiums).

167. *Id.* (reporting Medigap premiums grew on average 3.8% per year from 2001–2010).

168. *Id.* at 5, 16–17. The rates vary significantly by state, from a low in 2010 of \$129 on average in Michigan to \$219 in New York. *Id.* at 5. Insurers can charge older people more, offer discounts for women, non-smokers, or married people, and can medically underwrite people who do not enroll in an open-enrollment period. Most policies are “attained-age rated,” which means that premiums vary based on the age of the enrollee, getting relatively higher as an individual gets older. *Id.* at 9; *Cost of Medigap Policies*, MEDICARE.GOV, <http://www.medicare.gov/find-a-plan/staticpages/learn/how-insurance-companies-price-policies.aspx#;return%20false> (last visited May. 7, 2014).

169. CUBANSKI ET AL., *supra* note 147, at 34 fig.3.1. In 2010, about 60% had a Medicare Part D plan for prescription drugs, nearly 20% had coverage through an ESI retiree plan, and 13% had some other coverage. *Id.*

170. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066 (2003) (codified at 42 U.S.C. § 1395w-101 (2012)).

171. JACK HOADLEY ET AL., HENRY J. KAISER FAMILY FOUND., MEDICARE PART D: A FIRST LOOK AT PART D PLAN OFFERINGS IN 2013, at 2 (2012) (estimating 2013 premium weighted by enrollment, based on 2012 enrollment). Premiums for the four most popular plans, which together accounted for nearly 50% of the enrollee population in 2013, ranged from \$18.50 per month to \$43.77 per month. *Id.* at 7.

172. CONG. BUDGET OFFICE, SPENDING PATTERNS FOR PRESCRIPTION DRUGS UNDER MEDICARE PART D 2 (2011) (reporting that 40% of enrollees receive low-income subsidies); GRETCHEN JACOBSON ET AL., HENRY J. KAISER FAMILY FOUND., MEDICARE’S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 13 (2012) (describing qualification criteria for the Low-Income Subsidy Program, including that assets must be under \$11,570).

a. *Regulation of Medicare Under the ACA*

The ACA did not alter the structure of Medicare overall but made several changes to the program design that will reduce out-of-pocket spending for Medicare beneficiaries.<sup>173</sup> The most important change is the elimination of the Part D “donut hole” coverage gap, which will decrease cost sharing on prescription drugs by \$43 billion over ten years.<sup>174</sup> The donut hole was a gap in coverage that occurred after a beneficiary spent a certain amount on benefits.<sup>175</sup> Beneficiaries used to be responsible for 100% of total prescription drug costs in this donut hole until reaching a threshold for catastrophic coverage.<sup>176</sup> The ACA reduces this share from 100% to 25% of total costs by 2020.<sup>177</sup> Above the catastrophic threshold, the beneficiary pays only 5% of costs out of pocket and the plan pays the rest.<sup>178</sup> One study estimates that the ACA will decrease out-of-pocket spending for high prescription drug spenders by as much as one-third, but will have little impact on someone with median expenditures.<sup>179</sup>

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173. See ROBERT BERENSON & JOHN HOLAHAN, ROBERT WOOD JOHNSON FOUND. & URBAN INST., *HOW WILL THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AFFECT SENIORS?: TIMELY ANALYSIS OF HEALTH POLICY ISSUES 1-2* (2010). Some changes could increase out-of-pocket spending, but total spending on net is likely to decrease. See *id.*

174. See *id.* at 2. Part D led to a reduction of \$180 in annual out-of-pocket costs for the median participant and \$800 at the ninetieth percentile. GARY V. ENGELHARDT & JONATHAN GRUBER, CTR. FOR RET. RESEARCH, BOS. COLL., *DOES MEDICARE PART D PROTECT THE ELDERLY FROM FINANCIAL RISK?* 3-4 (2011), available at [http://crr.bc.edu/wp-content/uploads/2011/06/IB\\_11-8-508.pdf](http://crr.bc.edu/wp-content/uploads/2011/06/IB_11-8-508.pdf).

175. Historically, the initial coverage limit has ranged from \$2,250 to \$2,970 in total drug spending. *2014 Medicare Part D Outlook*, Q1MEDICARE.COM, <http://www.q1medicare.com/PartD-The-MedicarePartDOutlookAllYears.php> (last visited Jan. 28, 2014).

176. *Id.* A beneficiary will have paid up to \$4,550 in out-of-pocket spending, up to this point in 2014, before the new rules take effect. *Id.* Part of this amount may be paid by pharmaceutical companies, depending on what drugs an individual uses. *Id.*

177. ACA § 3301, 42 U.S.C. § 1395w-102(b)(2)(C)-(D) (2012). During the transition period until 2020, the ACA provides that the Medicare plan will increasingly subsidize generic and brand drug spending in the donut hole and drug manufacturers will provide a 50% discount on brand drugs. MEDICARE RIGHTS CTR., *THE AFFORDABLE CARE ACT: CLOSING THE DOUGHNUT HOLE 1-2*, available at <http://www.medicarerights.org/pdf/Closing-the-Doughnut-Hole-Chart.pdf> (last modified Jan. 1, 2014).

178. JACK HOADLEY ET AL., HENRY J. KAISER FAMILY FOUND., *ANALYSIS OF MEDICARE PRESCRIPTION DRUG PLANS IN 2012 AND KEY TRENDS SINCE 2006*, at 11 fig.1 (2012) (depicting cost sharing in Part D plans including catastrophic coverage).

179. See Paul Fronstin et al., *Notes: The Impact of Repealing PPACA on Savings Needed for Health Expenses for Persons Eligible for Medicare*, EMP. BENEFIT RES. INST., Aug. 2011, at 3 (basing estimates on spending for someone in the ninetieth percentile of drug spenders). Because the plan will be paying for a greater share of the costs of drugs, premiums may increase somewhat.



To illustrate what this change will mean, a Part D beneficiary will be responsible for three components of cost sharing by 2020: (1) a deductible; (2) 25% of costs in the coverage gap; and (3) 5% of drug costs thereafter.<sup>180</sup> If these new rules were in effect now, a beneficiary could spend as much as: (1) \$310 on the deductible; (2) \$1,536 through the former donut hole (25% of the amount of spending above the deductible up to the catastrophic limit); and (3) 5% of any spending over the catastrophic limit (\$6,455 in total spending). Maximum cost sharing would be just under \$1,850 up to the catastrophic level and then 5% thereafter.

The top prescription drug users still bear some catastrophic spending risk. About 3% of non-low-income beneficiaries reach the catastrophic level,<sup>181</sup> mostly because of spending on specialty drugs for chronic conditions.<sup>182</sup> For those who reached the catastrophic threshold, nearly one-half of their total drug expenditures occur above that threshold.<sup>183</sup> But because the beneficiary's out-of-pocket share of these expenditures is so low, the beneficiary spends on average just under \$300 out of pocket above the catastrophic level.<sup>184</sup>

The net effect of other ACA policies on Medicare beneficiary out-of-pocket spending is unclear. Some policies will likely reduce out-of-pocket spending, such as the elimination of cost sharing for preventive care<sup>185</sup> and pricing and delivery reforms to slow Medicare

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180. CONG. BUDGET OFFICE, *supra* note 172, at 3, 7. This description is for a standard plan. Only about 10% of enrollees who do not qualify for the low-income subsidy are in a plan with the standard plan design. One-third are enrolled in an actuarially equivalent plan and the rest are in "enhanced" plans, where they pay higher premiums for greater benefits. *Id.* at 4; see also JACK HOADLEY ET AL., HENRY J. KAISER FAMILY FOUND., MEDICARE PART D 2010 DATA SPOTLIGHT: A COMPARISON OF PDPs OFFERING BASIC AND ENHANCED BENEFITS 1 (2009), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8034.pdf> (reporting higher percentages of non-LIS beneficiaries in basic, standard or actuarially equivalent plans).

181. CONG. BUDGET OFFICE, *supra* note 172, at 5.

182. *Id.* at 6–7. Some specialty drugs fall under Part B coverage instead and could also lead to high out-of-pocket costs through Part B cost sharing. See Peter A. Ubel et al., *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEW ENG. J. MED. 1484, 1484 (2013) (estimating that a patient with metastatic colorectal cancer and only Medicare might pay \$8,800 out of pocket over a normal course of first-line chemotherapy treatment).

183. CONG. BUDGET OFFICE, *supra* note 172, at 6. In 2008, the catastrophic phase started after \$5,726 in total spending, which means on average each individual also incurred roughly \$5,700 of spending in the catastrophic phase and paid \$285 (or 5%) of this amount out-of-pocket. *Id.* at 3.

184. Of course, spending is unevenly distributed among those whose spending exceeds the threshold, which means some of these people likely spent little and others spent well above the \$285 average.

185. See ACA §§ 4104–4108, 42 U.S.C. §§ 1395–1396 (2012).

cost growth overall.<sup>186</sup> Yet, certain ACA policies could increase out-of-pocket spending, at least for some people. For example, the law could erode comprehensive forms of supplemental coverage. It reduces the rates Medicare will pay to private Medicare Advantage plans, a form of supplemental coverage with limited out-of-pocket spending and relatively low premium costs.<sup>187</sup> This reduction might cause enrollment in these plans to drop by as much as one-third.<sup>188</sup> Likewise, the ACA might hasten the already ongoing erosion of retiree supplemental plans through their former employers with the so-called “Cadillac Tax” (an excise tax on high-cost, employer-sponsored health insurance).<sup>189</sup> People who lose their Medicare Advantage or Cadillac coverage might face higher out-of-pocket costs. Because the effect of these policies on net is unclear, they are not factored into the projected spending below.

*b. Projected Spending and Financial Risk*

As the above discussion evinces, Medicare beneficiaries face a complex picture of health insurance coverage. This complexity makes it difficult for retirees to understand their coverage and to predict spending.<sup>190</sup> Yet, the stakes of decisions with respect to retiree health insurance are high because a retiree could face very different spending, based on what coverage she chooses.

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186. See BERENSON & HOLAHAN, *supra* note 173, at 2–4 (discussing ACA efforts to reduce provider payment rates through the Independent Payment Advisory Board, Accountable Care Organizations, and other delivery reform policies).

187. Health Care Education Reconciliation Act, Pub. L. No. 111-152, § 1102, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C. (2012)). On average, the government had paid these private plans more per person covered by the plan than what it spent on Medicare fee-for-service beneficiaries. BERENSON & HOLAHAN, *supra* note 173, at 2.

188. CONG. BUDGET OFFICE, COMPARISON OF PROJECTED ENROLLMENT IN MEDICARE ADVANTAGE PLANS AND SUBSIDIES FOR EXTRA BENEFITS NOT COVERED BY MEDICARE UNDER CURRENT LAW AND UNDER RECONCILIATION LEGISLATION COMBINED WITH H.R. 3590 AS PASSED BY THE SENATE 3 (2010).

189. See ACA § 9001 (codified as amended at I.R.C. § 4980I (Supp. 2011)). Starting in 2018, benefits worth more than \$10,200 for an individual retiree or \$27,500 for two or more individuals will be subject to a 40% excise tax. *Id.* Other policies could have a similar erosive effect. For example, starting in 2013, the subsidy to employers who offer retiree drug coverage will also be taxed, eliminating an exemption created under the Medicare Modernization Act and costing employers an additional \$233 per retiree on average that must be reported as a liability in annual reports. PAUL FRONSTIN, EMP. BENEFIT RES. INST., NO. 338, ISSUE BRIEF: IMPLICATIONS OF HEALTH REFORM FOR RETIREE HEALTH BENEFITS 12 (2010).

190. See generally Hoffman & Jackson, *supra* note 14 (highlighting the mismatched expectations of retirees on their health care expenditures compared to expert estimates of costs).

If a retiree in a median retiree income household has only Original Medicare coverage plus drug coverage (Medicare Parts A, B, and D), she will have low baseline costs but could have high variable spending on cost sharing, as shown in Table 3A. She will spend only about 5% of median retiree income on premiums for Parts B and D.<sup>191</sup> But she risks unlimited cost sharing for inpatient and outpatient care and substantial cost sharing for prescription drugs. One study estimates that about one-third of Medicare beneficiaries without supplemental coverage would have out-of-pocket cost sharing of over \$5,000 and one-fifth of over \$7,000 during at least one year in a ten-year period.<sup>192</sup>

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191. As noted above, the median household income for someone over age sixty-five—from Social Security, retiree benefits, and other sources—is just over \$34,000. See CARMEN DENAVAS-WALT ET AL., *supra* note 29, at 6 tbl.1.

192. GLENN HACKBARTH & TRICIA NEUMAN, MEDICARE PAYMENT ADVISORY COMM'N & KAISER FAMILY FOUND., MEMORANDUM: AN ANALYSIS OF THE SHARE OF MEDICARE BENEFICIARIES WHO WOULD BENEFIT FROM AN ANNUAL OUT-OF-POCKET MAXIMUM OVER MULTIPLE YEARS 2 (2013).

**Table 3A: Maximum Out-of-Pocket (OOP) Spending in Scenario Considering Retiree with Original Medicare**

	Determinants of OOP Spending			Total Possible OOP Spending	Maximum Percentage of Income***
	Annual Premium	Cost Sharing	Uncovered Care		
<b>Part A</b>	Free	\$1,216 for hospitalization  \$304 daily for days 61-90  \$608 daily for days 91 to 150  All costs after 150 days	No new mandated benefits under the ACA**	<i>Unlimited cost sharing</i>	Highly variable
<b>Part B</b>	\$1250	\$147 deductible and 20% co-insurance		\$1,250 premium + <i>unlimited cost sharing</i>	
<b>Part D</b>	\$480	~\$2,135*		~\$2,615*	
<b>TOTAL Retiree with Original Medicare</b>	\$1,730	<i>Unlimited spending on cost sharing</i>	• <i>Risk of spending on uncovered essential care</i>	\$1,730 on premiums + <i>unlimited cost sharing &amp; spending on uncovered care</i>	5% on premiums + <i>unlimited cost sharing &amp; spending on uncovered care</i>
* Based on an average spender in top 3%. \$310 deductible plus 25% of spending to catastrophic threshold) plus 5% thereafter (~\$285 on average for top 3% of spenders <sup>193</sup> ).					
** Gaps that predate the ACA include no coverage of long-term care, dental care, hearing aids, private nursing care, and limited prescription drug coverage of commonly used drugs in some plans. These gaps create high potential that a beneficiary will have some spending on uncovered essential care.					
*** Percentage estimates are based on the median household income for households over age sixty-five.					

Original Medicare, both predating and following ACA implementation, protects the average retiree, who does not use very

193. For explanation of the \$285 estimate see *supra* notes 183–84 and accompanying text.

much care and thus does not face high cost sharing. But it leaves those retirees with serious or unusual medical conditions to struggle in the face of unlimited cost sharing, unless they have other coverage. Medicare policy relies on the fact that most retirees will either obtain supplemental health insurance to reduce or eliminate variable spending or will deplete their income and assets to levels low enough that they qualify for Medicaid supplemental coverage.<sup>194</sup>

When retirees obtain supplemental coverage, they invert the concept of financial security under Original Medicare of low baseline cost and high variable spending and catastrophic risk, replacing it with higher baseline costs but low variable spending and catastrophic risk, as illustrated in Table 3B. This is in effect the definition of financial security that most retirees choose. Premiums alone for the typical retiree might cost over \$4,000, or 12% or more of median retiree income. There is still some risk of variable spending from cost sharing on prescription drugs, which could result in as much as \$6,265 in total out-of-pocket spending or nearly one-fifth of income for someone with median retiree household income. This picture of financial security looks more like the one for exchange enrollees with private coverage, one of high premiums, some variable spending, and low catastrophic risk with respect to spending on covered benefits.

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194. *Seniors & Medicare and Medicaid Enrollees*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html> (last visited Jan. 9, 2014) (describing low-income eligibility for Medicaid).

**Table 3B: Maximum Out-of-Pocket (OOP) Spending in Scenario Considering Retiree with Medicare Coverage and Average Supplemental Medigap Coverage**

	Determinants of OOP Spending			Total Possible OOP Spending	Maximum Percentage of Income***
	Annual Premium	Cost Sharing	Uncovered Care		
<b>Part A</b>	Free	\$0	No new mandated benefits under the ACA**	\$0	0%
<b>Part B</b>	\$1,250	\$0		\$1,250	4%
<b>Part D</b>	\$480	~\$2,135*		~\$2,615*	8%
<b>Medigap</b>	\$2,400	\$0	N/A	\$2,400	7%
<b>TOTAL Retiree with Medicare and Medigap</b>	\$4,112	\$2,135	•Risk of spending on uncovered essential care	\$6,265 + unlimited spending on uncovered care	19% + unlimited spending on uncovered care
* Based on an average spender in top 3%. \$310 deductible plus 25% of spending to catastrophic threshold) plus 5% thereafter (~\$285 on average for top 3% of spenders <sup>195</sup> ).					
** Gaps that predate the ACA include no coverage of long-term care, dental care, hearing aids, private nursing care, and limited prescription drug coverage of commonly used drugs in some plans. These gaps create high potential that a beneficiary will have some spending on uncovered essential care.					
*** Percentage estimates are based on the median household income for households over age sixty-five.					

However, as Tables 3A and 3B illustrate, Medicare beneficiaries might also spend a significant amount on uncovered goods and services, whether they have supplemental coverage or not. Medicare covered benefits were mostly untouched by the ACA. Medicare and even most Medigap plans do not cover long-term care, vision care,

195. See *supra* note 183–84 and accompanying text.

dental care, hearing aids, or private nursing care.<sup>196</sup> A large number of Medicare beneficiaries use these benefits. For example, 41% used dental services in 2008 and spent just under \$700 on average; 16% of beneficiaries spent more than \$1,000 on uncovered dental services, and nearly 10% spent over \$2,000.<sup>197</sup> Furthermore, many Medicare Part D plans do not include some of the top ten most commonly used brand drugs on their formularies, and, instead, only cover them at higher cost-sharing levels with utilization management restrictions, including quantity limits.<sup>198</sup> For example, Celebrex, a popular pain-relief drug that costs about \$300 per month, is off formulary for over one-quarter of enrollees and Lyrica is on a non-preferred tier for one-third of enrollees, doubling the insured's share of the cost of the drug.<sup>199</sup> With the exclusion or non-preferred treatment of such popular drugs, out-of-pocket exposure to prescription drug costs remains significant,<sup>200</sup> despite the ACA's efforts to reduce it. In sum, Medicare beneficiaries are in theory less vulnerable overall to spending on uncovered medical care than those with ESI. Yet, because the categories of benefits that are typically not covered are commonly used, spending on uncovered care is more likely to cause some retiree households financial strain.

Married couples with Medicare could be worse off than single retirees, depending on their income. They could incur double the costs and still not qualify for low-income subsidies, which are available only for households with incomes up to 150% of the federal poverty level (in contrast to 400% for exchange plans).<sup>201</sup> Their total out-of-pocket spending over the course of the year on premiums and Part D cost sharing could be as much as \$12,500. On top of this amount, they might incur spending on uncovered items. Arguably, this couple is in a more tenuous position than most of the people in the other cases discussed above.

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196. See CUBANSKI ET AL., *supra* note 147, at 20. According to this study, these expenditures were nearly one-quarter of total out-of-pocket spending; the major components of out-of-pocket spending in 2006 for all retirees (including those with any form of supplemental coverage) were: premiums (39%), long-term care (19%), medical providers and supplies (15%), prescription drugs (14%), dental (6%), and inpatient and outpatient hospital costs (5%). *Id.* at 70.

197. KAISER FAMILY FOUND., ORAL HEALTH AND MEDICARE BENEFICIARIES: COVERAGE, OUT-OF-POCKET SPENDING, AND UNMET NEED 3 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8325.pdf>.

198. HOADLEY ET AL., *supra* note 178, at 6–7 (2012).

199. *Id.* at 7.

200. Fronstin et al., *supra* note 179, at 3 (showing high rates of out-of-pocket spending for retirees in the seventy-fifth and ninetieth percentile of prescription drug users).

201. See *supra* notes 155, 172 and accompanying text.

Three observations are evident from this final set of scenarios looking at retirees with Medicare. First, she faces a much more complex set of decisions when attempting to piece together financial protections than either of the younger individuals considered here do.<sup>202</sup> The ACA could have simplified this picture to increase the chances that retirees did not face financial insecurity due to low transparency, but lawmakers chose not to do so. Second, retirees face high catastrophic spending risk unless they obtain supplemental coverage. Buying supplemental Medigap and Part D coverage affords a retiree considerable protection against catastrophic spending risk. A retiree might still incur some cost-sharing obligations for prescription drug costs and for items and services not covered by her plans.<sup>203</sup> Finally, a retiree's premiums for supplemental coverage are likely to consume a high percentage of income. Thus, health care regulation, including most recently the ACA, results in a definition of financial security for most retirees based on high premiums but very limited variable spending and catastrophic risk from spending on *covered* benefits.

### III. DISCUSSION

#### *A. A Summary of Financial Risk and Security in the Three Scenarios*

The financial protections provided by the ACA improve financial security in all of the above scenarios but in different ways and to different degrees. Likewise, after full implementation of the ACA, Americans with insurance are still vulnerable in different ways. Table 4 offers a stylized summary of financial risk due to health care spending following full implementation of the ACA.

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202. A retiree could simplify decisions somewhat by selecting a Medicare Advantage with a Prescription Drug plan, otherwise known as Medicare Part C, which combines the benefits of Medicare Parts A, B, and D. Twenty-eight percent of Medicare beneficiaries were enrolled in these plans in 2013. MARSHA GOLD ET AL., HENRY J. KAISER FAMILY FOUND., MEDICARE ADVANTAGE 2013 SPOTLIGHT: ENROLLMENT MARKET UPDATE 1 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf>.

203. If she chooses a plan with less comprehensive coverage, she might be exposed to higher out-of-pocket spending at the point of service.



Table 4: High-Level Summary of Financial Risk in Three Scenarios of Insurance Coverage

	Premium Spending Risk	Variable Spending Risk on Covered Benefits	Catastrophic Spending Risk	
			on Covered Benefits	on Uncovered Care
Individual with Exchange Coverage	Medium	Medium	Low	Low
Worker with Employer Plan	Low	Low-Medium	Low	Medium*
Retiree with Medicare & Medigap	High	Low-Medium	Low	Medium**
* Potential amount of spending could be high but the probability is low.				
** Potential amount of spending is relatively lower but the probability is high.				

Table 4 suggests a few key takeaways. After the ACA is implemented, premiums will not in themselves pose high spending risk for most of the working-age population. Only retirees with Medicare and Medigap are likely, as a whole, to spend more than 10% of income on premiums. Some older exchange enrollees might also spend over 10% on premiums if living in an expensive state. The burdens of premiums increase as people age, evincing a regulatory choice not to eliminate age-based premiums, despite reducing their magnitude.

Once insured people use medical care, most face some risk of variable spending on covered benefits. For exchange plans and ESI, the ACA attempts to reduce, but not to eliminate, the potential for variable spending on most covered benefits through the cost-sharing limits on essential health benefits. Most people with ESI have additional limits on top of, and sometimes lower than, the ACA limits. For retirees, the ACA, in conjunction with earlier Medigap regulation, ensures that those with supplemental Medigap coverage

will spend very little on covered medical care and considerably less on prescription drugs than they would have before the ACA.

Variable cost sharing on covered benefits no longer poses catastrophic spending risk for any of the groups. The ACA has attempted to create consistency in this regard: it attempts to ensure that anyone with insurance should be able to afford necessary care covered by her health insurance plan.<sup>204</sup>

Some insured, however, still face high variable and catastrophic spending risk on uncovered care. For exchange plans, the limits on out-of-pocket spending on essential health benefits, when combined with the mandate that plans cover these benefits, all but eliminate catastrophic spending risk. But the ACA created the potential for a significant gap in future ESI coverage by not mandating employer plans cover these essential health benefits. To the extent an employer decides not to cover categories of care, some employees will have to pay for this type of care completely out of pocket and will thus face the risk of very high spending. The likelihood of this spending on uncovered care is low, based on the current state of employee benefits, but the potential amount of spending if employers reduce benefits is high. Like those with ESI, retirees may incur out-of-pocket spending on uncovered care that might be medically necessary, including on dental and vision care and long-term care.

Thus, the ACA limits variable spending on covered benefits for all three populations. Yet, workers with ESI and retirees still face catastrophic risk for spending on uncovered and potentially essential care.

This picture reveals that after full ACA implementation, for each population, health policy reduces certain aspects of financial risk but leaves insured people vulnerable to other aspects. Health policy has, in effect, created three different regulatory definitions of financial security for the three populations considered:

For the individual buying silver-level exchange coverage, financial security is defined as *low catastrophic risk*.

For the worker with ESI, regulatory deference to employers reinforces the employers' definition of financial security, which typically results in *low baseline spending* and relatively *low variable spending* and *low catastrophic risk* on covered benefits.

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204. Because the ACA cost-sharing limits do not apply to non-essential benefits in ESI plans, spending on these benefits could still be unlimited if an employer plan does not limit cost sharing on all covered benefits by its terms.

For a retiree with Medicare and Medigap, it is a picture of financial security as *low variable spending* and *low catastrophic risk* for spending on covered benefits.

However, each scenario reveals that insured individuals may still struggle in the face of health care spending in the post-ACA environment, regardless of their type of insurance:

Exchange enrollees may incur moderate to high recurrent baseline spending. That is, they will reliably spend a substantial amount every year on premiums plus variable spending on cost sharing, even if healthy.

Although most employer plans are currently relatively comprehensive, workers may face catastrophic risk of spending on uncovered, *essential* benefits if employers choose not to cover categories of care. Workers may also face moderate risk of variable spending on cost sharing on covered benefits, as employers continue to increase cost sharing in light of growing health care spending, but no more than allowed by the ACA limits.

Finally, retirees may face both high baseline spending, from high premiums plus some cost sharing on prescription drugs, and also risk of catastrophic spending on uncovered care, even if long-term care is excluded from the picture. They are the only population that, as a whole, must contend simultaneously with high spending in a typical year and the potential for catastrophic spending in a bad year.

The above scenarios thus reveal ways in which Americans will enjoy different financial protections and will face different types of threats to financial security from health care spending after full implementation of the ACA.

*B. Evaluation of the Inconsistent Picture of Financial Risk After the ACA*

The question of whether this inconsistent picture is normatively desirable—or perhaps politically necessary, even if not ideal—remains. While answering this question is necessarily beyond the scope of this brief discussion, this Section begins to tease out some key considerations.

This heterogeneous picture of financial protections and risk at first blush might seem to suggest that the ACA has created a marketplace for financial security, where insured could choose the

type of coverage that best meets their individual preferences for health care spending risk. This theory, however, fails for two reasons. First, as before the ACA, consumers still generally cannot move fluidly between these different types of insurance. Someone who buys exchange coverage likely does not have access to an employer plan. A worker with an employer plan must give up employer contributions and beneficial tax treatment of spending on health care if opting out of ESI and obtaining exchange coverage instead. Although this tradeoff might make sense for some low-income workers if they qualify for exchange subsidies, it would not for most middle-income workers. Medicare beneficiaries are not eligible for exchange subsidies. And most people with exchange coverage and employer plans do not yet qualify for Medicare. Second, even if a marketplace existed among these types of coverage, it would not be one consumers could easily understand and navigate. The different pictures of financial risk for different forms of coverage are extremely opaque to the average consumer. Even if they were transparent, consumers typically struggle with decisions that involve risk or uncertainty, such as those concerning health insurance.<sup>205</sup>

A second possibility is that the regulations are intentionally tailored to best meet the particular needs of the insured in each group. While consistency may be easier from a consumer perspective, it might make policy sense for protections to vary if aligned with the needs and resources of different populations. Perhaps consumer groups have demanded the best protections they could garner for people with exchange coverage, labor unions and employee advocates have demanded what is most important for those with employer plans, and the AARP has secured the financial protections most desired by retirees with Medicare and Medigap. Is it possible that the ACA is a story of democratic success, where each definition of financial security best fits the needs of the relevant group of insured, in light of political constraints? Consider each in turn.

For the person with a silver-level plan from the individual market exchange, the ACA creates protection from catastrophic risk, but a forty year-old worker could spend from 10% of median household income in a healthy year to as much as 20% in an unhealthy one on

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205. For an overview of cognitive biases with respect to risk and uncertainty, see Christine Jolls & Cass R. Sunstein, *Debiasing Through Law*, 35 J. LEGAL STUD. 199, 203–25 (2006); see also Howell E. Jackson, *Accounting for Social Security Benefits*, in BEHAVIORAL PUBLIC FINANCE 261, 271–75 (Edward J. McCaffery & Joel Slemrod eds., 2006) (illustrating the “range of cognitive biases that may affect participant perceptions of the value of Social Security benefits”).

premiums and cost sharing. Is this definition and, in particular, the possibility for high baseline spending in exchange for low catastrophic risk during key working years sensible for someone who seeks out coverage on an exchange?

Perhaps an individual with median household income should reasonably expect to spend a share of that income on health care. Most people consider their health important. Someone in her working years may have other compelling expenses, especially if raising children, building a career, or paying off educational debt. But the ACA subsidy structure takes into account the higher cost of living for a family, as opposed to an individual, as illustrated above. In addition, someone at the age of forty has more flexibility to adjust earnings or to borrow in any one year, if necessary, to cover a year or two of relatively bad health. And the ACA limits the magnitude of spending, even in a bad year, so that, in theory, recovery from such a year is now easier.

On the flip side, this level of spending may be too much to expect many American households to manage on a continuing basis. One touchstone scholars have used is that spending more than 10% of income on health care is too high.<sup>206</sup> By this rule, most exchange coverage would fail. Studies have shown that far smaller amounts of spending can trigger bankruptcy.<sup>207</sup> Young workers have fewer assets and less credit history to support borrowing. Household income has stagnated over the past twenty years, shrinking disposable income so that health care spending at the levels likely for exchange enrollees may conflict with spending on other basic needs.<sup>208</sup> By this logic, this model's high baseline may cause more people more angst.

The bottom line for the exchange population is that the ACA does not eliminate spending—in fact, for some it requires spending a considerable portion of income on premiums and cost sharing even in the typical year—but it attempts to eliminate catastrophic spending potential on those items and services considered “essential.”<sup>209</sup> Thus, the key question going forward is whether the level of spending required in a typical year is consistent with financial security for this

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206. See Jessica S. Banthin et al., *Financial Burden of Health Care, 2001–2004*, 27 HEALTH AFF. 188, 189 (2008).

207. See Jacoby & Holman, *supra* note 2, at 265 (finding that over 80% of respondents in bankruptcy study reported medical debts of under \$5,000).

208. See Reinhardt, *supra* note 132.

209. Of course any items not considered “essential” would be financed completely out-of-pocket, which makes the definition of “essential” a critical consideration.

population or whether it might, in itself, unacceptably threaten a family's financial security.

This question is difficult to answer definitively *ex ante*. The vehement opposition to the individual mandate and resistance among some Americans to buying exchange policies suggests that they fear unmanageable baseline spending. And the media has seized upon the cost of premiums as a problem for middle class purchasers.<sup>210</sup> Many Americans are not accustomed to allocating a significant portion of their income to health care spending. On the other hand, doing so might serve some of them in the long run, by helping them to smooth health care spending, rather than taking (and perhaps losing) a gamble that they will not need expensive medical care.

It is worth noting that the high baseline costs some face after the ACA regulation are largely the result of larger systemic spending problems, not the effect of individual underwriting leading to high premiums for some insured. Health care utilization patterns and prices make the United States the top country in terms of spending per capita on health care.<sup>211</sup> The way to reduce this high baseline out-of-pocket spending for individual exchanges enrollees is either to address underlying health care spending or to increase subsidies. Concern with high baseline spending for exchange enrollees might increase pressure to ameliorate the larger underlying cost problem.

For the worker in an employer plan, the ACA largely did not tackle the problem of financial security head on. Rather, it affirms a regulatory definition of financial security protections that predated the ACA and is based on an employer's definition. Does this deference make sense?

From one perspective, this deference might have been wise. It is part of an attempt not to disrupt relatively good coverage predating the ACA. In its current form, most ESI protects workers well from financial risk due to out-of-pocket health care spending, especially when compared to all other insured. The typical worker with ESI will pay very little out of pocket on health care, even in an unhealthy year.

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210. See, e.g., Katie Thomas et al., *New Health Law Frustrates Many in Middle Class*, N.Y. TIMES, Dec. 21, 2013, at A1; Julie Appleby, *Some Middle-Class Families Find Price Of Subsidized Health Coverage 'Awfully High,'* KAISER HEALTH NEWS (Feb. 10, 2014), <http://www.kaiserhealthnews.org/Stories/2014/February/10/Middle-class-families-subsidized-insurance-premiums.aspx> (explaining that the middle class is caught in the position of earning too much income to receive a subsidy, but not enough income to be indifferent to cost).

211. OECD, OECD HEALTH DATA 2013: HOW DOES THE UNITED STATES COMPARE 1 (2013) (reporting \$8,508 per capita spending in the United States, as compared to an OECD average of \$3,339).

And the ACA limits both variable spending and catastrophic risk for spending on essential benefits in ESI plans, to the extent an employer covers these benefits. This means that if an employer covers essential health benefits, employees with ESI will almost certainly spend less out of pocket than other insured. This deference might also be based on a belief that the market will check employers who try to offer less comprehensive benefits.

On the other hand, the ACA's deference could simply signal the influence of strong business interests over the legislative process and could leave workers vulnerable in the long run. The ACA preserves, and perhaps exacerbates, the potential for high spending on uncovered items and services. While the risk of coverage gaps is more theoretical than realized, the ACA does nothing to guarantee comprehensive ESI benefits. Assumptions that the market will police these plans can only go so far. The bare-bones "mini-med" coverage offered by many employers, such as McDonalds, and the lack of coverage by others, most notoriously Walmart, offer evidence that not all employers will choose definitions that protect workers financially and not all workers can bargain for better.

All insured face some risk of spending on uncovered items, to different degrees. From one perspective, this risk might not pose a public policy concern. If insurance covers a basic core of services that are fundamentally important to health and wellbeing, perhaps spending outside that core of services should be discretionary and borne individually.<sup>212</sup> For example, if an individual wants to try an experimental and expensive fertility treatment or one with low effectiveness or benefit, protecting her against this type of spending may be a lower social priority than protecting her against the first-line treatment for breast cancer. This prioritization ensures that shared resources are spent in ways that are of the highest social value.

Yet, from a social welfare perspective, spending on uncovered services is a concern if health insurance regulation has done a poor job of shaping coverage. After the ACA, an employee with ESI is, in theory, at the greatest risk in this regard. In the other two scenarios considered, regulators have defined core benefits, ideally with social welfare concerns in mind, even if some gaps exist. If employers do not

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212. Cf. Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523, 545–60 (2014) (proposing an approach to improve efficiency in the use of medical care by rating treatments by value level and enabling consumers to contract for services based on value level, paying more for lower-value services and less for higher-value ones).

prioritize their employees' financial wellbeing, spending on uncovered and essential services could pose catastrophic financial risk.<sup>213</sup>

On balance, the risk workers face is more theoretical than real at the moment, which means that those with ESI still face the least potential for out-of-pocket spending, following ACA implementation. To the extent employers scale back benefits to a level that poses public policy concerns, however, it may be necessary to end regulatory deference on the terms of ESI benefits.

Finally, for Medicare beneficiaries, Original Medicare preserves low baseline costs in exchange for high potential catastrophic risk. However, regulators act under the presumption that 90% of retirees will not rely on Medicare alone for coverage. For most, the purchase of private supplemental coverage inverts the final risk profile, which affords retirees relatively low catastrophic risk in return for high baseline costs. In this way, the definition of financial security for retirees looks similar to that for people buying coverage on the exchanges. Highly regulated, private supplemental plans reduce catastrophic risk in exchange for high premiums.

Before the ACA, Medicare beneficiaries were arguably the best protected from financial risk, and individually insured under age sixty-five were the most vulnerable of all insured. Following full implementation, Medicare beneficiaries are more vulnerable in several ways than younger insured who buy exchange plans. First, even if premiums consume a similar share of income for a member of each group with median household income, the ACA provides premium and cost-sharing subsidies for exchange coverage for those earning up to 400% of the federal poverty level, significantly more generous than the subsidies available to retirees, only up to 135%.<sup>214</sup> Second, with the exchanges, the ACA attempts to create a marketplace with higher transparency and clearer choices so that individuals can tradeoff premiums and cost-sharing risk to some degree. Regulation of private Medigap plans has created a marketplace that is too opaque for retirees to make meaningful

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213. In addition, even if benefits covered are comprehensive, if insurance networks are insufficient, enrollees might be forced to go out of network for services, incurring either a larger percentage of or all of the costs of treatment for even core services. State regulators might monitor the sufficiency of networks for the individual market or exchange plans, but employers who self-insure can typically design networks however they might choose.

214. See *supra* note 155 and accompanying text. Subsidies are available up to 150% of the federal poverty level for prescription drug coverage. See *supra* note 172 and accompanying text.



choices among supplemental coverage options. In response, most opt for the highest level of coverage in Plan F. If instead of being categorized by letters that have no meaning to consumers, Medigap plans were arrayed on a dimension of value and sold in a way that retirees might understand, more like exchange plans, beneficiaries would have a chance to make more educated tradeoffs.<sup>215</sup>

Finally, Medicare beneficiaries likely face higher risk of spending on essential uncovered items than those with exchange coverage. The ACA includes most of the items and services someone with exchange coverage would use in the mandated essential health benefits. Medicare's coverage gaps are more likely to leave retirees without benefits in areas where they need care. Even with supplemental coverage, many spend significant amounts on drugs that are only covered in part or not at all under their Part D plans or on dental or vision care, as well as on long-term care. A retiree with few other necessary expenses may be able to manage this spending. On the other hand, most median-income retirees have fixed income and insufficient savings, and spending on uncovered health care could easily compromise their basic standard of living.

When viewed in comparison to the other forms of insurance coverage following implementation of the ACA, some retirees are in a relatively vulnerable position with high baseline costs and still the potential for catastrophic spending risk. Of course, they can rely on Medicaid as a safety net, but they must first deplete their assets and compromise their standard of living significantly to do so. This result could be avoided through more generous Medicare premium subsidies and reconsideration of what covered benefits should be treated as essential for retirees.

In sum, it is not obvious that the resultant inconsistency in financial protections for insured people is designed deliberately to best meet the needs of each group.<sup>216</sup> Thus, this particular regulatory status quo should be disrupted if aspects of it prove undesirable as the ACA is implemented.

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215. The ability to make educated tradeoffs, both for exchange enrollees and for retirees, is admittedly limited by low financial literacy and the complexity of insurance purchase decisions, even assuming the insurance exchanges eventually function smoothly. Cf., e.g., Jackson, *supra* note 205; Jolls & Sunstein, *supra* note 205.

216. This inconsistency might, however, represent the best protection possible for each group, in light of the political compromise necessary to pass the ACA. Of course, that moment of political compromise does not necessarily preclude changes, whether legislative or regulatory, later.

## CONCLUSION

This Article has shown that the ACA is likely to reduce financial risk from health care spending for Americans. However, it does so differently depending on the type of health insurance an individual has. The result is different points of financial vulnerability for each insured group. In addition, the ACA may create a more complex total picture than is necessary. Individuals who move from one type of insurance to another over their lifetimes must learn a new system and a new strategy for protecting themselves against unmanageable health care spending. A system with more consistent protections and expectations throughout life's circumstances and phases would be much easier for consumers to understand and navigate. Thus, although improving the financial security of Americans on balance, the ACA also represents a missed opportunity to simplify financial protections and to create a more equitable system of such protections among types of health insurance.

The places where the highest risk remains for an average American household—baseline spending for exchange enrollees, catastrophic spending on uncovered care for employer insurance, and baseline spending plus the possibility of catastrophic spending on uncovered care for retirees—could result in unacceptable levels of financial insecurity for some Americans. With a fragmented structure comes a heightened monitoring obligation to ensure that some subsets of the population are not especially vulnerable. As ACA implementation continues, these areas of greatest vulnerability must be carefully watched and measured to determine which points of vulnerability should be the target of future health policy.

