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## *IN BRIEF*

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### ***RESPONSE***

#### PPACA IN THEORY AND PRACTICE: THE PERILS OF PARALLELISM

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“In theory there is no difference between theory and practice.  
In practice there is.”

Yogi Berra<sup>1</sup>

**P**ARALLEL pathways are pervasive. Blood flows from the heart to the brain through three separate arteries; in the event of a blockage in one artery, blood is routed through the other two. We have two kidneys but need only one. If I want to drive from Champaign to Charlottesville, I can go by way of I-70 or I-80, or I can explore the blue highways. If I want to get from Champaign to Chicago, I can fly, take the bus, drive, or take the train. If I drive to Chicago and get caught in traffic on the Dan Ryan expressway, the side streets are always an option. And so on.

Parallel pathways can operate simultaneously or non-simultaneously. Simultaneous pathways are generally preferable since they provide an increased margin of safety from real-time redundancy.<sup>2</sup> Both kidneys work continuously; they do not alternate

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<sup>1</sup> Yogi Berra, Wikiquote, [http://en.wikiquote.org/wiki/Yogi\\_Berra](http://en.wikiquote.org/wiki/Yogi_Berra) (last visited Aug. 24, 2011).

<sup>2</sup> Conversely, sequential pathways are employed when having both pathways operate simultaneously is impractical, risky, or otherwise not feasible.

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or take vacations. The same goes for eyes and ears. The existence of multiple modes of transit between Champaign and Chicago means I can almost always get there, one way or another. The Boeing 777 can fly on only one engine, but both engines are used simultaneously. If you want to be safe, a “belt and suspenders” approach is better than either one alone.<sup>3</sup>

What, if anything, do parallel pathways have to do with the Patient Protection and Affordable Care Act (“PPACA”), apart from the coincidental usage of two “Ps” in each? In their insightful and tightly reasoned article, Professors Monahan and Schwarcz work their way through a series of interlocking provisions in PPACA and explain how they make it possible for employers to “dump” high-risk employees onto the state-run exchanges scheduled to commence operations in 2014.<sup>4</sup>

Stated less pejoratively, PPACA makes it possible for employed workers to obtain health insurance coverage through either their employer or an insurance exchange, with differing financial (and potentially health) consequences depending on whether the employer is offering affordable coverage (or coverage at all) and the income and health status of the employee. This parallel pathway expands the options through which employees can get to their desired (and/or mandated) destination—having health insurance.

The existence of a parallel pathway can also create problems. Previous scholarship has focused on whether the exchanges will destabilize the employment-based coverage (“EBC”) market because of the substantial subsidies for low-income workers (whether low-risk

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<sup>3</sup> See, e.g., Peter Orszag, A “Belt and Suspenders” Approach to Fiscally Responsible Health Reform, Office of Mgmt. and Budget Blog (June 1, 2009, 11:07 AM), <http://www.whitehouse.gov/omb/blog/09/06/01/ABeltandSuspendersApproachtoFiscallyResponsibleHealthReform> (“Our cost containment falls into two categories: Medicare and Medicaid savings that are key to achieving scoreable savings over the medium term but that by themselves would be unlikely to generate substantial long-term efficiency improvements in the health system, and ‘game-changers’ that are unlikely to generate significant scoreable savings in the medium term but that are crucial to moving toward a health system that addresses the issues discussed in Atul Gawande’s compelling New Yorker article. . . . This belt-and-suspenders approach means we are not just banking on the long-term impact from the game changers to protect the budget.”). But see *Once Upon A Time In The West* (Paramount Pictures 1968) (“How can you trust a man who wears both a belt and suspenders? Man can’t even trust his own pants.”).

<sup>4</sup> Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 Va. L. Rev. 125, 127–29 (2011).

or high-risk) to obtain coverage through the exchanges.<sup>5</sup> Monahan and Schwarcz focus on a more subtle problem: because of the way PPACA is designed, employers can encourage high-risk employees to enroll in the exchanges, while keeping low-risk employees in EBC. The result of such adverse selection will be cheaper EBC and more expensive exchange-based coverage than would otherwise be the case.

What should we think of this particular design detail of PPACA, and what, if anything, should we do about it? Monahan and Schwarcz argue that the parallel pathway they identify is a serious design defect, which will result in major adverse consequences:

[T]here is a substantial prospect that PPACA will lead some, and perhaps many, employers to implement a targeted dumping strategy designed to induce low-risk employees to retain [EBC] but incentivize high-risk employees to voluntarily opt out of ESI [employer sponsored insurance] and instead purchase insurance through the exchanges that [PPACA] establishes to organize individual insurance markets. Although [PPACA] and other federal laws prohibit employers from excluding high-risk employees from [EBC], these laws do little to prevent employers from designing their plans and benefits to incentivize high-risk employees to voluntarily seek coverage elsewhere. If successful, such a targeted dumping strategy would allow employers and low-risk employees to avoid the costs associated with providing coverage to high-risk employees, thereby lowering (perhaps substantially) the costs of coverage under the employer's group plan.<sup>6</sup>

Monahan & Schwarcz are appalled at this prospect and issue a clarion call demanding immediate reform: “[I]t is imperative for lawmakers to preemptively respond to the prospect of employer dumping.”<sup>7</sup> Their rhetoric reflects their passionate, normative assessment of the problem they identify. If the problem is not fixed, it will result in “dumping,” which will allow employers to avoid their “responsibility” to provide employees with insurance that is com-

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<sup>5</sup> See, e.g., David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a “Game Changer?”*, in 1 N.Y.U. Rev. Emp. Benefits & Executive Compensation 1A-1, 1A-13–14 (Alvin D. Lurie ed., 2010).

<sup>6</sup> Monahan & Schwarcz, *supra* note 4, at 128.

<sup>7</sup> *Id.* at 188.

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prehensive and not risk rated.<sup>8</sup> If employers succeed in “gaming” the requirements of PPACA, it will “corrode the willingness of the broader American population to shoulder the expenses of our country’s comparatively high-cost population.”<sup>9</sup> This “threat” creates a major risk that health reform will be “undermined.”<sup>10</sup> Given these normative preferences, it is unsurprising that Monahan and Schwarcz respond with nine possible legislative and regulatory reforms.

What is there to be said for Monahan and Schwarcz’s diagnosis of the problem and their recommended treatment? Part I of this Response provides some useful background on EBC. Part II identifies several difficulties with Monahan and Schwarcz’s analysis, and Part III concludes.

### I. EBC 101

EBC is a dominant reality of American health policy, but as I observed in an earlier article cited by Monahan and Schwarcz, it is the “Rodney Dangerfield of health policy: it gets no respect from anyone.”<sup>11</sup> EBC covers approximately sixty percent of the non-elderly population, but employers are unenthusiastic about their role in this market. As Rick Wagoner, the former head of General Motors aptly observed, “[w]hen I joined GM 28 years ago, I did it because I love cars and trucks. I had no idea I’d wind up working as a health care

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<sup>8</sup> Id. at 132 (“Rather than sharing medical risks on a community basis at the employer level, targeted employer dumping would allow employers and low-risk employees to avoid the responsibility of cross-subsidizing the health care costs of high-risk employees.”).

<sup>9</sup> Id. (“[Dumping] could corrode the willingness of the broader American population to shoulder the expenses of our country’s comparatively high-cost population. . . . [E]mployers cannot be allowed to game health care reform by dumping only their sickest employees onto state insurance exchanges.”).

<sup>10</sup> Id. at 131 (“Most importantly, employer dumping of high-risk employees could undermine the exchanges on which individual markets are expected to operate by rendering the pool of policyholders seeking coverage in exchanges disproportionately risky relative to the general population.”); see also id. at 132 (“[T]he threat posed by the prospect of strategic employer dumping of high-risk employees can be addressed through various statutory, and even regulatory, reforms.”).

<sup>11</sup> David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 *Yale J. Health Pol’y L. & Ethics* 23 (2001). For additional background on EBC, see Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*, 27 *Health Aff.* 6, W539–40 (2008), available at <http://content.healthaffairs.org/content/27/6/w533.full.pdf>.

administrator.”<sup>12</sup> Wagoner was not exaggerating; as one political commentator cuttingly framed the issue in 2005, “is General Motors an automobile manufacturer that provides healthcare benefits for its workers? Or is it a health insurance provider that also happens to make cars?”<sup>13</sup>

Employers are unenthusiastic because EBC is expensive and getting more so far more quickly than any other cost input. The average annual premium for family coverage in 2009 was \$13,375, with the employer directly paying \$9,860.<sup>14</sup> From the employer’s perspective, the cost of health insurance ranged from 6.8% (nonunionized workers) to 12.3% (unionized workers) of payroll—exceeding the combined amount spent by employers on Medicare, Social Security, unemployment insurance, and workers’ compensation, and substantially exceeding the cost of retirement benefits.<sup>15</sup>

The last decade has seen some erosion of EBC “in response to rising health care costs and larger macroeconomic trends, with the smallest employers showing the largest relative and absolute decline.”<sup>16</sup> There have also been simultaneous changes in the breadth and depth of coverage, the number of employees that qualify for coverage, the choice of providers that are “in-network” or “out-of-network,” and the degree of point-of-purchase cost to the employee. All of these factors affect “uptake rates,” since employees must decide to “opt-in” to coverage in order to receive it.

From a functional perspective, employers use EBC to help attract and retain qualified workers; lower absenteeism, sick pay, and disability costs; and increase productivity. The sizeable tax subsidy provides an additional inducement to bundle health insurance with employment. From the employee’s perspective, health insurance

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<sup>12</sup> George F. Will, *What Ails GM*, Wash. Post (May 1, 2005), <http://www.washingtonpost.com/wpdyn/content/article/2005/04/29/AR2005042901385.html>.

<sup>13</sup> Jeff Jacoby, *GM’s Healthcare Dilemma*, Boston Globe, June 16, 2005, at A19.

<sup>14</sup> Kaiser Family Found. & Health Research & Educ. Trust, *Employer Health Benefits: 2009 Annual Survey* 1, 1 exhibit A (2009), available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.

<sup>15</sup> News Release, Bureau of Labor Statistics, *Employer Costs For Employee Compensation—June 2011* (Sept. 8, 2011), available at <http://www.bls.gov/news.release/pdf/ecec.pdf>; see also U.S. Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in the United States*, March 2009 (Sept. 2009), <http://www.bls.gov/ncs/ebs/benefits/2009/benefits.htm>.

<sup>16</sup> Hyman, *supra* note 5, at 1A-3.

helps fund necessary health care, promotes health, and protects employees and their dependents from the financial costs associated with poor health.

How will PPACA change these dynamics? As noted above, past commentary has focused on whether PPACA will cause employers to drop coverage entirely.<sup>17</sup> Monahan and Schwarcz identify a different risk—that PPACA will encourage employers to change their terms of coverage in ways that will make EBC less appealing to high-risk employees. If the appropriate financial sweeteners are deployed, Monahan and Schwartz predict the result will be the disaggregation of the EBC risk pool. A new separating equilibrium will develop, as high-risk employees migrate to the exchanges and low-risk employees remain in EBC. Such risk classification by design (“RCBD”) is a standard strategy for segregating insurance applicants by relative risk.<sup>18</sup> Monahan and Schwarcz are the first to point out how PPACA

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<sup>17</sup> *Id.* at 1A-13-14.

<sup>18</sup> Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 *Conn. Ins. L.J.* 371, 378 n.15 (2003) (“A decision to market insurance to a given target audience classifies that audience as being composed of members with favorable risk characteristics. For example, Medicare HMOs are prohibited from underwriting (i.e. turning away sick applicants), but they are free to design their marketing so that it appeals to healthy, active seniors. Billboards featuring seventy-five year-old men doing gymnastics and free health club memberships are two ways to do this. . . . Contract drafting can also serve a risk classification function. A decision to offer a given type of coverage as an “extra” rather than as a standards [sic] coverage provided by a broad form policy can reflect a judgment that the insurance company cannot identify (classify) individuals who are particularly risky with respect to that type of coverage. Thus, requesting that coverage amounts to self-classification as being risky in that way.”); Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 *U. Pa. L. Rev.* 1577, 1608 (2011) (“Risk classification by design is my new term for the economic phenomenon that Joseph Stiglitz explored in his Nobel prize winning work on markets with asymmetric information. In a foundational paper with Michael Rothschild published in the 1970s, Stiglitz . . . showed in mathematical terms that insurance products can be designed to appeal differentially to people with different risk characteristics, so that people self-select into separate risk pools in a manner that correlates with their risk status. . . . High health risk people tend to prefer more complete health insurance coverage, fewer restrictions on their choice of doctors, and other plan features that make it easier to consume more health care.”); see also Alma Cohen & Peter Siegelman, *Testing for Adverse Selection in Insurance Markets*, 77 *J. Risk & Ins.* 39 (2010) (examining the frequency of adverse selection in various insurance markets). But see Hanming Fang, Michael P. Keane & Dan Silverman, *Sources of Advantageous Selection: Evidence from the Medigap Insurance Market*, 116 *J. Pol. Econ.* 303, 342 (2008) (finding that low-risk people prefer more costly insurance in some circumstances).

creates a sizeable incentive for employers to engage in RCBD on a more comprehensive and aggressive basis.

## II. SOME COMPLICATIONS

There is much to admire in Monahan and Schwarcz's article. The piece combines a close reading of statutory provisions with a sophisticated understanding of how employers, employees, and regulators interact and how private insurance markets have performed in the past. The authors have carefully analyzed how the different pieces of PPACA work together and how PPACA is likely to interact with a complex and dynamic private market for health insurance coverage. Lastly, they understand how seemingly minor design choices can have disproportionate consequences. And, they have done all this in record time, posting a full-blown version of their article on the Social Science Research Network just under four-and-one-half months after PPACA was enacted.<sup>19</sup> That said, there are at least seven factors that complicate their analysis and conclusions.

### A. Possibility v. Plausibility

PPACA makes it possible for employers to engage in broad-based RCBD, but it does not follow that they will do so on anything near the scale envisioned and deplored by Monahan and Schwarcz. For employers to view RCBD as a viable proposition (that is, one with a positive return on investment), employers will have to be able to:

- cost-effectively differentiate high-risk and low-risk workers and their families;<sup>20</sup>

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<sup>19</sup> PPACA was signed into law on March 23, 2010, followed a week later by the "side-car" bill (the Health Care and Education Reconciliation Act of 2010). Monahan and Schwarcz posted their completed article on SSRN.com on August 2, 2010—132 days after PPACA was enacted.

<sup>20</sup> Monahan and Schwarcz suggest that the potential savings from excluding high-risk workers and their families are large, citing studies on the concentration of health care spending, and that chronic illness is responsible for seventy-five percent of health care spending. Monahan & Schwarcz, *supra* note 4, at 181–83. There is no question that health care spending is highly concentrated; that, after all, is why health insurance exists, even in a purely voluntary market. And it is also clear that chronic illness accounts for a heavily disproportionate share of health care spending. But these observations do not add up to a finding that the same people are responsible across multiple years for elevated health care spending. To the extent there is substantial variation in health care

- design coverage that will be appealing to the latter but not the former;
- come up with sufficient financial sweeteners to cover the gap period so high-risk employees are willing to opt out of EBC and into an exchange;
- persuade high-risk employees who cannot figure things out on their own that they are better off in the exchange;
- avoid paying too much or too little as a sweetener;
- avoid spending too much on human resources to administer the benefit package;
- avoid or defuse the political heat of being “caught” engaging in “bad” RCBD;
- make continuous adjustments to ensure that the RCBD strategy is working; and
- decide each year that the benefits of continuing to engage in RCBD exceeds its costs and that RCBD works better than either sticking with a non-RCBD strategy or just dumping coverage entirely.

Monahan and Schwarcz offer several strategies by which employers could engage in RCBD, while acknowledging the limitations and trade-offs of each. For example, limited provider networks might be less appealing to high-risk employees, whom one should expect to want more access to specialists. But that strategy could backfire (at least as judged by its ability to encourage the departure of high-risk employees), to the extent limited provider networks are substantially cheaper (as they usually are) and result in higher quality health care (as they often do). Similar complications apply to the other strategies proposed by Monahan and Schwarcz.<sup>21</sup> To their credit, Monahan and Schwarcz concede low-risk employees have “complicated desires” and that “an effective employer dumping strategy is not simple to construct.”<sup>22</sup> Indeed, they explicitly refer to the difficulty of creating a cost-effective RCBD strategy as “thread[ing a] needle.”<sup>23</sup> Given these challenges, it is far from clear whether employers will actually develop and deploy a RCBD strategy, when they

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spending on those who are chronically ill, it substantially complicates the determination of which employees’ families are high-risk.

<sup>21</sup> The other strategies are outlined in Monahan & Schwarcz, *supra* note 4, at 158–71.

<sup>22</sup> *Id.* at 156, 159.

<sup>23</sup> *Id.* at 159.



can either continue what they were doing already or simply drop EBC entirely.<sup>24</sup>

If we do not actually know whether RCBBD is going to turn out to be a real problem, and we will not know for sure for several years, it is not obvious that we should spend time and effort building a fire-wall against something that may turn out to be a nonproblem. It is hard to improve on the observation of President Calvin Coolidge: “If you see ten troubles coming down the road, you can be sure that nine will run into the ditch before they reach you.”<sup>25</sup> The gap between possibility and plausibility indicates that it might be prudent to wait and see whether RCBBD is one of the nine problems that will run into the ditch or the one we will have to do battle with.<sup>26</sup>

### B. Priorities

Even if RCBBD turns out to be a real problem, it does not follow that there will be much interest or urgency in fixing it. First, problems vary in severity—and as noted above, we will not know how severe RCBBD will turn out to be until at least a year or two after the exchanges start operating in 2014. If the problem is not particularly severe, Congress is unlikely to try to fix it. Even if RCBBD is a real and severe problem, Congress still might not take action, since it has shown an extraordinary ability to kick the can down the road on problems far larger than RCBBD (for example, Social Security, Medicare, and the deficit).<sup>27</sup>

Second, even if RCBBD turns out to be an important problem, fixing it may still not be a priority if other problems demand our attention first—with “demand” dictated both by objective necessity and the

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<sup>24</sup> Of course, there are other alternatives, including spinning off low-wage workers into a separate company and then allowing them to obtain coverage from the exchange.

<sup>25</sup> John Cook & Leslie Ann Gibson, *The Book of Positive Quotations* 499 (Steve Deger & Leslie Ann Gibson eds., 2d ed. 2007).

<sup>26</sup> Russell Korobkin, *Possibility and Plausibility in Law and Economics*, 32 Fla. St. U. L. Rev. 781, 788 (2005).

<sup>27</sup> Of course, the Administration could try to fix RCBBD through regulation, but as Monahan and Schwarcz make clear, regulatory responses to the problem are significantly under-powered. Monahan & Schwarcz, *supra* note 4, at 188 (“Although the most effective responses to the problem are statutory, several regulatory efforts may at least mitigate its scale.”). Regardless, it is not obvious that RCBBD will rise to the top of the regulatory agenda, given all the other challenges associated with the implementation of PPACA.

visibility and salience of the problem. Without a politically salient example of “bad” behavior and a champion for the “fix” within Congress, it is far from clear that the issue will ever rise to the top of the legislative agenda.

A medical analogy helps make the point. When one is faced with a medical emergency, the priorities are the things that will kill the patient immediately and not whether the patient has a broken arm or a problem that may kill him or her in a week, month, or year. For the first few years after the exchanges go into effect, the problem of RCBD is likely to be treated as more akin to a sprained ankle—perhaps upgraded eventually to a broken leg. It is not going to be treated like a cardiac arrest or an arterial bleed, both of which require an immediate life-saving response. PPACA already has a surplus of immediate and dramatic problems that require fixing; getting legislators and regulators to focus on the prevention of future problems seems like a distinct long-shot.

Finally, even if RCBD turns out to be a big problem, the speed with which the problem manifests itself makes a substantial difference in whether it will be prioritized. If the consequences of RCBD emerge gradually, it will be relatively easy to explain away the deterioration of the exchanges as a consequence of factors other than dumping (such as structural problems in the coverage provided through the exchanges, insufficient sanctions for non-coverage, or the natural evolution of the coverage market). I fully expect there will be no shortage of lawyers to make such arguments on behalf of employers who are accused of “dumping.”

### *C. Setting the Baseline*

How should we determine whether employers are engaging in dumping? Monahan and Schwarcz implicitly use the essential health benefits as determined by the Department of Health and Human Services (which will apply to coverage secured through the exchanges) as the baseline against which self-funded coverage will be measured—with deviations presumptively (but hopefully not irrefutably) attributable to covert and overt attempts to engage in dumping. Given the dynamics that are likely to apply to the determination of these essential health benefits, such assumptions are simply unwarranted. Indeed, Monahan has written elsewhere about the perilous circumstances under which essential health benefits will be de-

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terminated—including the presence of powerful anecdotes and the difficulty public entities will face in taking costs into account.<sup>28</sup> These problems dogged the determination of mandated benefits at the state level, and there are many reasons to think the problem will be worse at the federal level. Preliminary evidence suggests as much:

Maggie Haslam's five-year-old autistic son, Drew, has undergone intense behavioral, physical and speech therapy that helped him learn to dress himself and communicate such concepts as "over" and "under." The therapy greatly helped Drew, said Ms. Haslam, a public-relations agent in Silver Spring, Md. But was it essential? The next big issue for the federal health law as it moves toward implementation is how regulators will define so-called essential benefits—the basic medical services that health plans must cover under the law. The legislation gives 10 categories of care that plans must provide for customers of the health-insurance exchanges that are launching in 2014. But the law leaves details up to regulators, who are now starting to develop the rules. Habilitative services, used by such patients as Drew, have become a contentious point in the debate. Unlike rehabilitation, which helps patients recover skills they have lost, habilitation helps patients acquire new skills. Such services can be costly because the process can take years, and insurers haven't typically covered many of them, sometimes labeling them educational or experimental. The debate over exactly what habilitative services to include in the new rules—and how much of them—exemplifies the challenge of defining what health benefits are truly essential. This week, insurers and patient groups are expected to face off at a meeting hosted by the Institute of Medicine, which has been charged by the Department of Health and Human Services with making recommendations on defining criteria for deciding what are essential bene-

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<sup>28</sup> See Amy B. Monahan, Initial Thoughts on Essential Health Benefits, *in* 1 N.Y.U. Rev. Emp. Benefits & Executive Compensation 1B-1, 1B-12-13 (Alvin D. Lurie ed., 2010) ("[I]ndividuals will have the opportunity to suggest which benefits to cover, and often these comments will be driven by personal anecdote. These anecdotes are very powerful. For example, if an individual submits a comment stating that her life was saved by an experimental cancer treatment, it is hard to say no to coverage, absent some rubric to guide such a decision. We have seen examples at the state and federal level of such anecdotal evidence leading to coverage mandates that are not supported by sound data.").

fits. Lobbying on all categories has been intense, and the institute has received over 330 comments from groups including insurers, patient advocates and medical professionals.<sup>29</sup>

Given these dynamics, there is no compelling reason to treat the results of such processes as the proper baseline for comparison with self-funded coverage, nor should deviations be treated as attributable to RCBD. Further, if we do not have a defensible baseline against which to measure “proper” coverage, it will be extremely difficult to distinguish between RCBD, random variation, and coverage tailored to the interests and needs of a particular employer’s work force.

#### *D. Fixing the Problem?*

Monahan and Schwarcz offer ten strategies (five regulatory and five legislative) to address RCBD.<sup>30</sup> As with their diagnosis, they do a nice job of laying out the costs and benefits of all ten strategies—including the extent to which they target the problem (that is, the degree to which they are under- and over-inclusive). But they say nothing about the political economy of enacting and implementing reform, nor the intersection of that issue with the administrability of their proposed reforms.

For starters, Monahan and Schwarcz do not explain how any of their reforms will get adopted in the first place. Self-insured employers had the political power to get an exemption from the essential health benefits requirements when PPACA was enacted.<sup>31</sup> Is there any reason to think that this dynamic has changed? Employers will find it very easy to play defense, given the multiple veto gates through which reform must pass.

Similar considerations are likely to dog attempts to administer the proposed reforms, if they are somehow enacted. Regulators will

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<sup>29</sup> Avery Johnson, *Defining ‘Essential’ Care*, Wall St. J., Feb. 28, 2011, at A3.

<sup>30</sup> Monahan & Schwarcz, *supra* note 4, at 189–97.

<sup>31</sup> Monahan, *supra* note 28, at 1B-11–12 (“A final possibility is that the exception for self-insured plans was driven by effective lobbying on the part of both large employers and the self-insurance industry, both of which likely enjoy the lack of substantive regulation. In the heated debates leading up to the passage of PPACA, it is understandable why self-insured plans, which cover a large number of working Americans, would have considerable political sway. It is also easy to understand why self-insured plans would have effective political arguments about not interfering with a market that already provides insurance coverage to a great many Americans.”).

be required to develop and apply defensible rules for differentiating dumping from justifiable coverage variation and from accidental or idiosyncratic preferences. “I know it when I see it”<sup>32</sup> will not cut it when we are dealing with health insurance—a dynamic product with attributes that vary along multiple dimensions and which is offered to different risk pools that are themselves in flux. Indeed, the task of determining on a case-by-case basis whether a particular self-insured health plan qualifies as “minimum essential coverage”—when the content of that coverage can change yearly, there are thousands of such entities to consider, and the relevant risk pools vary as well—would tax the capacity of even the most dedicated of regulators. Similar difficulties are likely to apply to determinations to specify the outer boundaries of “subterfuge” and to implement a limited preexisting condition term for employees who are dumped.<sup>33</sup> Such problems are less likely to apply to the more mechanical reforms identified by Monahan and Schwarcz (that is, changes to the Internal Revenue Service regulations so payment of insurance premiums does not count as an eligible expense in a Health Reimbursement Account, absolute ineligibility for the exchange if one can obtain EBC, broader employer penalties, and application of the essential health benefit provisions to all self-insured plans).<sup>34</sup> Yet the willingness of the Department of Health and Human Services to waive provisions of PPACA for some (but not all) applicants means that even mechanical reforms will require considerable judgment.<sup>35</sup>

The most important problem with Monahan and Schwarcz’s ten reforms, however, is the one they identify at the outset: “[A]ll of these solutions, to one extent or another, increase the prospect that employers will drop coverage altogether, as they deprive employers of the option to selectively dump high-risk employees.”<sup>36</sup>

I had assumed that this prospect would be seen as a huge negative, akin to destroying the village in order to save it. It is certainly

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<sup>32</sup> *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

<sup>33</sup> Monahan & Schwarcz, *supra* note 4, at 192.

<sup>34</sup> *Id.* at 189–97.

<sup>35</sup> See, e.g., Richard A. Epstein, *Government by Waiver*, *Nat’l Aff.*, Spring 2011, at 39, 51–52, available at [http://www.nationalaffairs.com/doclib/20110317\\_Epstein.pdf](http://www.nationalaffairs.com/doclib/20110317_Epstein.pdf).

<sup>36</sup> Monahan & Schwarcz, *supra* note 4, at 188.

completely inconsistent with President Obama's repeated pledge that PPACA would not result in anyone losing his or her coverage:

During the 2008 campaign, (then Senator) Obama routinely promised "if you like your coverage you can keep it." Even ABC News thought the promise was "not literally true," but Senator Obama had found a winning slogan, and he stuck to it. President Obama repeated and expanded this claim during the battle over health reform, flatly claiming in a speech to the AMA that, "no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what."<sup>37</sup>

Monahan and Schwarcz are untroubled. Indeed, they resolutely insist that "the consequences of such employer decisions to drop coverage entirely are much less troubling than the prospect of employer dumping of high-risk employees."<sup>38</sup> I explain below why I think Monahan and Schwarcz are wrong on this point. But even if they are right, this means that their reforms may well result in the dumping of a sizeable number of high-risk *and* low-risk employees onto the exchanges, after some (or many?) employers respond by eliminating EBC entirely. Alternatively, if Monahan and Schwarcz are right *and* we do nothing to prevent RCBD, high-risk employees will voluntarily migrate to the exchanges, making them and their low-risk coworkers and employers better off. Why should we assume, as Monahan and Schwarcz do, that the former outcome (which disrupts coverage for more people, and increases the on-budget costs) is preferable to the latter?

#### *E. Compared to What?*

RCBD only "works" if the targeted high-risk employees prefer the exchanges to EBC. It is far from clear whether that will actually happen. Monahan and Schwarcz highlight the statutory promise to deliver comprehensive coverage and a range of providers and assume that promise will be delivered on. But Medicaid makes similar promises, and everyone knows how that has worked out. If you

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<sup>37</sup> Hyman, *supra* note 5, at 1A-11-12.

<sup>38</sup> Monahan & Schwarcz, *supra* note 4, at 188.

think having Medicaid gives you access to health care services, call a dozen physicians' offices, tell them you have Medicaid, and see how soon they will give you an appointment, if at all. Similar difficulties are starting to emerge for Medicare.<sup>39</sup>

There is also likely to be considerable state-by-state variation in how well the exchanges perform, which complicates matters for employers that operate in multiple states. Should such employers design their RCBD strategy around the preferences of high-risk employees in the state with the "best" exchange, the "worst" exchange, or the median state exchange? Unless multi-state employers are willing to separately tailor their benefits on a state-by-state basis (which is precisely what the Employee Retirement Income Security Act was intended to avoid), they could end up with a RCBD strategy that is too strong in some states and too weak in others. The more complex the necessary calculations and the more frequent the necessary adjustments, the easier it becomes for employers to conclude the costs of playing the RCBD game simply are not worth the candle.

#### *F. Politics*

Monahan and Schwarcz completely ignore politics. Indeed, the only sentence in their lengthy article that even touches on the issue is the conclusory statement that "Republicans and Democrats alike should be able to agree that employers cannot be allowed to game health care reform by dumping only their sickest employees onto state insurance exchanges."<sup>40</sup>

I am skeptical that Republicans and Democrats can agree on much of anything with regard to PPACA, other than repealing the 1099 reporting requirements.<sup>41</sup> The House of Representatives has already

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<sup>39</sup> See David Olmos, *Mayo Clinic in Arizona to Stop Treating Some Medicare Patients*, Bloomberg (Dec. 31, 2009), <http://www.bloomberg.com/apps/news?pid=21070001&sid=aHoYSI84VdL0>; Press Release, Am. Med. Ass'n, *AMA Releases 22 New "Patient Access Hot Spots" Nationwide—Medicare Cuts to Physicians Will Make Problem Worse* (Oct. 21, 2009), available at <http://www.ama-assn.org/ama/pub/news/news/patient-access-hot-spots.page#>; Jacob Goldstein, *A Mayo Clinic Outpost Won't Take Medicare*, Wall St. J. Health Blog (Dec. 31, 2009, 3:40 PM), <http://blogs.wsj.com/health/2009/12/31/a-mayo-clinic-outpost-wont-take-medicare>.

<sup>40</sup> Monahan & Schwarcz, *supra* note 4, at 132.

<sup>41</sup> Until it was repealed, Section 9006 of PPACA required all corporations to issue 1099 tax forms to any individual or corporation from which they bought more than

voted to repeal PPACA and is now attempting to defund implementation.<sup>42</sup> The run-up to the 2012 Presidential election has begun, and opposition to PPACA is likely to be a critical factor in selecting the Republican nominee—a fact that has created considerable difficulty for Mitt Romney, whose Massachusetts health reform legislation provided the basic template for PPACA.<sup>43</sup> In Congress, PPACA has more opponents than defenders, and almost none of the defenders are enthusiastic about the statute. PPACA is the most blatantly partisan and divisive piece of social reform legislation in the past half-century; the only thing bipartisan about PPACA was the opposition to it.<sup>44</sup> Democrats hoped that PPACA would become more popular once it was enacted, but it proved to be a political albatross in the 2010 midterm elections. Most of the ads run by Democrats during the fall of 2010 that mentioned PPACA were highlighting the fact that they had voted against it.<sup>45</sup> If anything, PPACA has gotten less

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\$600 in goods or services in a tax year. The House voted 314 to 112 in favor of repeal. In the Senate, the vote was 87 to 12. President Obama signed the bill into law on April 14, 2011.

<sup>42</sup> Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (as passed by the House, Jan. 19, 2011), available at <http://www.gpo.gov/fdsys/pkg/BILLS-112hr2eh/pdf/BILLS-112hr2eh.pdf>; see, e.g., David Brooks, Buckle Up for Round 2, N.Y. Times, Jan. 7, 2011, at A19 (cataloging the ways in which the Republicans will make implementation of PPACA difficult); Albert R. Hunt, No Silver Lining for Democrats in Elections Rout, Bloomberg (Oct. 3, 2010), <http://www.bloomberg.com/news/print/2010-10-03/no-silver-lining-for-democrats-in-elections-rout-albert-r-hunt.html> (observing that [Republicans] “can wreak havoc with the measure’s implementation by denying money for creating insurance exchanges to help 30 million uninsured Americans get coverage; not funding the Department of Health and Human Services or new enforcement agents for the Internal Revenue Service[;] and nixing complicated rules and regulations.”).

<sup>43</sup> Ryan Lizza, Romney’s Dilemma, New Yorker, June 6, 2011, at 38, 42–43; see also Editorial: Mitt Romney’s RomneyCare Problem, Investors Bus. Daily (Apr. 12, 2011), <http://www.investors.com/NewsAndAnalysis/Article/568926/201104121902/Mitt-Romneys-Key-Quandary.htm> (“Former Massachusetts Gov. Mitt Romney begins his second bid for the presidency with an albatross around his neck. The sooner he admits his state version of ObamaCare was a mistake, the better.”).

<sup>44</sup> See Henry J. Aaron, The Midterm Elections—High Stakes for Health Policy, 363 New Eng. J. Med. 1685, 1685, 1686 tbl. (2010) (quantifying the magnitude of bipartisan support for major social reform legislation prior to PPACA and the strictly partisan vote for (and bipartisan opposition to) PPACA).

<sup>45</sup> See, e.g., Johnathan Cohn, Playing Offense on Health Care Reform, New Republic (Oct. 1, 2010, 12:01 PM), <http://www.tnr.com/blog/jonathan-cohn/78098/Russ-Feingold-Campaign-Ad-Defends-Health-Care-Reform> (“Most Democrats campaigning for election right now have downplayed health care reform, except for those who have actually boasted of their votes against it.”).



popular post-enactment, despite continuing efforts to market the law.<sup>46</sup> According to a recent poll, two-thirds of Americans support repealing the individual mandate—yet the Administration is defending the mandate in multiple courts as an essential component of PPACA.<sup>47</sup>

Given these dynamics, I seriously doubt there are many votes among the Democrats to amend PPACA in order to prevent a problem that may not materialize for several years, if ever. Most Democrats in Congress would rather talk about any subject under the sun

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<sup>46</sup> For a summary of the polls and a review of efforts to market PPACA, see Peter Suderman, *The Sisyphean Struggle to Sell ObamaCare*, Reason Mag. (Mar. 21, 2011), <http://reason.com/blog/2011/03/21/the-sisyphean-struggle-to-sell>; see also Health Insurance Reform Reality Check, White House, <http://www.whitehouse.gov/realitycheck/> (last visited Aug. 21, 2011); Brooks Jackson, *Mayberry Misleads on Medicare*, The FactCheck Wire (July 31, 2010, 12:36 PM), <http://www.factcheck.org/2010/07/mayberry-misleads-on-medicare/>; Jane Norman, *White House Works to Turn Young Adults into Fans of the Health Care Law*, The Commonwealth Fund (Mar. 25, 2011),

<http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2011/Mar/March-28-2011/White-House-Works-to-Turn-Young-Adults.aspx>. At least one high-profile effort to market PPACA has tanked entirely. See Jennifer Haberkorn, *Where Are the Health Care All-Stars?*, Politico (Mar. 23, 2011), <http://dyn.politico.com/printstory.cfm?uuid=375E8388-7C97-4D51-A2E7-75C9034929EB> (“Democrats are under siege as they mark the first anniversary of health care reform Wednesday—and they won’t get much help from the star-studded, \$125 million support group they were once promised. Wal-Mart Watch founder Andrew Grossman unveiled the Health Information Campaign with great fanfare last June. Tom Daschle and Ted Kennedy’s widow, Vicki, were expected to lead the effort. They’d have help from former White House Communications Director Anita Dunn. They’d have an office in Washington with 10 or 15 operatives backing the Affordable Care Act and those who supported it. And they’d have money to spend: Grossman hoped for \$25 million a year for five years. But nine months later, the Health Information Campaign has all but disappeared. Its website hasn’t been updated since the end of last year. Its executive director and communications director are gone. There’s no sign that it has any money. And neither Daschle nor Dunn will return calls asking about it.”).

<sup>47</sup> Jason Millman, *Judges’ Agreement on Healthcare Penalties not Being a Tax is Key*, The Hill Healthwatch (Feb. 27, 2011, 5:22 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/146331-judges-agreement-on-healthcare-penalties-not-being-a-tax-is-crucial-point> (“The political problem for Democrats is that it doesn’t really matter what you call it—the individual mandate remains largely unpopular. A Kaiser Family Foundation poll this week found that two-thirds of Americans support repealing the individual mandate. Supporters of the law say the individual mandate is necessary to expand coverage while including new consumer protections, such as a ban on discriminating against preexisting conditions and dropping individuals from health coverage for an unintentional clerical error. But the provision’s unpopularity has centrist Democrats scrambling to pitch alternatives to the individual mandate.”).

other than health reform and rightly understand that attempting to fix a particular provision in PPACA will reopen the entire debate. Republicans are happy to point out the problems in PPACA, but they have no incentive to fix a defect in President Obama's signature initiative—particularly when they can use any failures or inadequacies of PPACA to permanently discredit what they will describe as a “budget-busting, job-killing, nanny-state” piece of legislation. Maybe people in Minnesota are nicer,<sup>48</sup> but in Washington, D.C., the political calculation is straightforward: when you see your opponents drowning, you should throw them an anvil.<sup>49</sup>

### *G. Normativity*

Monahan and Schwarcz are scathing in their denunciation of the likely outcome if the design defect they identify is not fixed. Their normative take is plausible; who could possibly be in favor of “gaming,” “dumping,” and the “undermining” of health reform? The proper normative frame, however, is actually far from clear.

First, a note on rhetoric. Monahan and Schwarcz obscure the contestable nature of the normative terrain by describing the conduct as “dumping.” In health law and policy circles, patient “dumping” was the term used to describe economically motivated transfers of uninsured patients with serious medical conditions from one hospital emergency department to another.<sup>50</sup> Some horrific anecdotes resulted in newspaper and law review articles condemning the prac-

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<sup>48</sup> Cf. Minnesota Nice, Wikipedia, [http://en.wikipedia.org/wiki/Minnesota\\_nice](http://en.wikipedia.org/wiki/Minnesota_nice) (last visited Oct. 3, 2011) (“Minnesota nice is the stereotypical behavior of long-time Minnesota residents, to be courteous, reserved, and mild mannered. According to Annette Atkins, the cultural characteristics of Minnesota nice include a polite friendliness, an aversion to confrontation, a tendency toward understatement, a disinclination to make a fuss or stand out, emotional restraint, and self-deprecation.”).

<sup>49</sup> See Anonymous, quotation selected by James Carville for *Front Matter of Mary Matalin & James Carville, with Peter Knobler, All's Fair: Love, War, and Running for President* (1994). The underlying sentiment is bipartisan. See Peter Baker, *The Breach: Inside the Impeachment and Trial of William Jefferson Clinton* 42 (2000) (“This whole thing about not kicking someone when they are down is BS—Not only do you kick him—you kick him until he passes out—then beat him over the head with a baseball bat—then roll him up in an old rug—and throw him off a cliff into the pound [sic] surf below!!!!”) (text of an e-mail from one Republican staffer to another when the House of Representatives was considering whether to impeach President Clinton).

<sup>50</sup> David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 *Ind. L.J.* 797, 803 n.25, 810 n.46, 811 n.50 (1998).

tice.<sup>51</sup> Congress responded with the Emergency Medical Treatment and Active Labor Act (“EMTALA”), which forced hospitals to provide such treatment but made no provision for payment.<sup>52</sup> Not surprisingly, EMTALA has had a variety of unintended consequences and has metastasized far beyond its original, limited purpose.<sup>53</sup> The gruesome anecdotes that fueled support for the legislation, however, made “dumping” into a loaded word in health law and policy circles.<sup>54</sup> Language matters: “employer dumping” sounds inherently evil, while RCBD sounds wonky, boring, and incomprehensible. The choice of terminology weights the normative dice, just as it does with such terms as “patent troll,” “net neutrality,” “predatory lending,” “death tax,” and “death panels.”

Once the rhetoric is stripped away, it is far from obvious that RCBD has any moral significance whatsoever—let alone a negative normative valence. For RCBD to “work,” Monahan and Schwarcz are clear that it has to make employers and employees better off—both individually and collectively. That doesn’t sound like “dumping.” Instead, it sounds like everyone involved is using voluntary contracts to maximize their utility. Furthermore, the simultaneous availability of EBC and a state-run exchange provides more options to employers and employees, resulting in increased competition in the health insurance market. Who could possibly be against more competition?

The point may be easier to grasp if I frame it around transportation.<sup>55</sup> Minneapolis-St. Paul International Airport (“MSP”) is the home airport of Monahan and Schwarz. For decades, Northwest Airlines has handled a very high percentage of air traffic at MSP. Fares were high, but a passenger could fly non-stop to many destinations. Northwest recently merged with Delta, further expanding its domi-

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<sup>51</sup> See *id.* at 810.

<sup>52</sup> *Id.* at 812.

<sup>53</sup> David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 *Health Matrix* 29, 30, 52–53, 55 (1998).

<sup>54</sup> And not just health law and policy circles. In trade law and policy circles, dumping refers to selling goods in one market below the price charged in another market, a practice that is prohibited if it causes material injury to a domestic industry in the importing country. The word has a similar negative connotation in the context of environmental law and policy.

<sup>55</sup> See David A. Hyman, *Convicts and Convictions: Some Lessons from Transportation for Health Reform*, 159 *U. Pa. L. Rev.* 1999, 2008 (2011) (using the example of convict transportation to illuminate the failure of PPACA to address incentive problems in health care delivery).

nance, but then Southwest Airlines announced that it would start to serve MSP as well. If MSP follows the course of other airports to which Southwest has expanded, the result will be a significant drop in fares on the routes that Southwest serves, along with new options for passengers who do not necessarily want to continue flying the airline previously known as “North-Worst.”<sup>56</sup>

But if we apply the Monahan and Schwarcz framework, we should focus on the adverse consequences of Southwest’s market entry on Delta and its employees. To ensure Southwest does not engage in “cream-skimming,” they should be prohibited from tailoring their schedules, amenities, and fares to attract some customers and repel others. Similar regulatory efforts will be necessary to keep Delta from “dumping” undesirable passengers and routes. Does this massive regulatory effort still sound like a good idea—and to what end?

Monahan and Schwarcz are likely to respond that flyers internalize the full costs and benefits of their decisions, whereas RCBD creates externalities for taxpayers and others. But a new carrier and additional flights also create externalities in the form of increased congestion, fuel consumption and exhaust, and more late-night flights. In addition, PPACA is already projected to cause 14 million Americans to lose their EBC and join Medicaid or the exchanges even before the impact of RCBD is taken into account.<sup>57</sup> Externalities were built into PPACA from the get-go.

What of the undermining of health reform? Estimates vary on how large an impact PPACA will have on EBC, but any significant

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<sup>56</sup> Southwest has had this effect in other markets as well. See Randall D. Bennett & James M. Craun, U.S. Dep’t of Transp., *The Airline Deregulation Evolution Continues: The Southwest Effect* 1–10 (1993), available at <http://handle.dtic.mil/100.2/ADA299083>.

<sup>57</sup> Memorandum from Richard S. Foster, Chief Actuary, Office of the Actuary (Apr. 22, 2010), available at [https://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf) (“[A] number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program or receive subsidized coverage through the Exchanges. For example, some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees’—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges. Somewhat similarly, many part-time workers could obtain coverage more inexpensively through the Exchanges or by enrolling in the expanded Medicaid program. Finally, as mentioned previously, the per-worker penalties assessed on nonparticipating employers are relatively low compared to prevailing health insurance costs. As a result, the penalties would not be a substantial deterrent to dropping or forgoing coverage.”).

migration of low- and-moderate income workers from EBC into the exchanges will make the financial impact of RCBD seem insignificant by comparison. Why might PPACA cause such migration? As I noted in an earlier article, the answer lies in the differing cost and value of the subsidies to low and moderate income workers, depending on how they obtain coverage:

For low-wage workers PPACA provides substantial subsidies for coverage obtained through the exchange, while the tax code provides only modest subsidies for obtaining EBC. For high-wage workers, the subsidy pattern is reversed. After one factors in the penalty employers must pay if employees obtain coverage through the exchange rather than through EBC, it turns out that low-wage workers (i.e., those with incomes < 200–250% of the federal poverty level) and their employers are jointly better off financially if coverage is obtained through an exchange, with the precise cut-off and magnitude of the benefit affected by one's assumptions.<sup>58</sup>

Monahan and Schwarcz dismiss this problem, reasoning that as long as an entire employer-based risk pool moves to the exchange, there cannot be much, if any, adverse selection, and therefore there will not be a problem.<sup>59</sup> What they do not consider is that health reform is unsustainable if it dramatically increases costs (whether on-budget or off-budget), regardless of whether those increased costs result from the enrollment of disproportionately high-risk workers in the exchanges or because many more low- and moderate-income workers receive more expensive subsidies to purchase coverage. The problem is aggravated by the reality that the subsidies to purchase coverage through the exchange require a highly visible direct appropriation each year, while the subsidy for EBC is imbedded in the tax system and does not show up as a budgetary line-item.

Absent a robust theory explaining why employees should be locked into the particular set of benefits offered by employers and why attempts to regulate RCBD will not cause more distortions than leaving such matters to employer and employee choice, it is hard to justify using language like “dumping,” let alone take the additional

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<sup>58</sup> Hyman, *supra* note 5, at 1A-14.

<sup>59</sup> Monahan & Schwarcz, *supra* note 4, at 174.

regulatory steps to try and eliminate conduct that makes everyone involved better off. An argument that PPACA was designed to create completely separate risk pools might do some of the necessary work, but although PPACA had multiple objectives, creating entirely separate risk pools was not one of them. As such, one could readily view the simultaneous parallel pathway identified by Monahan and Schwarcz as a feature and not a bug.

### III. CONCLUSION

Monahan and Schwarcz have performed an important and valuable service by closely analyzing PPACA's design details and identifying a problem that had escaped legislators, policy analysts, and other scholars.<sup>60</sup> Their findings provide a cautionary lesson about the perils of attempting top-down comprehensive reform of a large, dynamic, and politically sensitive sector of the economy—particularly when the legislation emerges (as it always does) from a roiling stew of ambition, arrogance, incompetence, and sloth interspersed with frantic haste, vote buying and selling, and the requisite dispensing of goodies to favored groups.

Identifying the problem is, however, only the first step. One must also assess the impact of the problem and the costs and benefits of various ways of fixing the problem—including doing nothing. For all the clarity and precision that Monahan and Schwarcz bring to their diagnosis of the problem, their analysis of possible solutions is less compelling—and the legislative and regulatory strategies they identify are unlikely to be adopted anytime soon. A further problem: even if one or more of their proposed reforms are adopted, when practice does not conform to theory, one should expect the layering

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<sup>60</sup> Monahan and Schwarcz generously suggest that I had noticed the problem they identify and quote one of my articles to that effect. Monahan & Schwarcz, *supra* note 4, at 131 n.14 (citing Hyman, *supra* note 5, at 1A-15) (“To be sure, there are limits on the ability of employers to customize their coverage as they might wish in response to these incentives, including anti-discrimination provisions, the complexities of pricing coverage as the size of the pool declines, and employee push-back. The likely result is that some employers will make all-or-nothing coverage decisions for all employees in favor of ‘nothing,’ while others will experiment with changing the terms of coverage, and the boundaries of the firm and its staffing.”). Monahan & Schwarcz are far too generous; although I expected PPACA to have a range of effects, I had not thought about the dumping scenario they describe.

on of more elaborate and onerous fixes, each justified on the basis of the failure of the previous “reform.”

When comparative institutional imperfection is the rule, leaving well enough alone is often sufficient unto the day.<sup>61</sup> And, if you can't leave well enough alone, it is still sensible to wait and see if the problem you have identified is one of the nine that roll into a ditch and are never heard from again. Stated more broadly, markets are imperfect, but so are regulators and legislators.

Monahan and Schwarcz have done a first-rate job identifying a potential future problem—but it is not unreasonable to hope for a bit more modesty about means and ends, given all that has happened before and since the enactment of PPACA—including the mountain of waivers that the Administration has had to issue in order to keep health reform from imploding before it even gets off the launching pad.<sup>62</sup>

One final irony. PPACA would not have passed unless it was deemed to be “affordable”—which in Washington meant that it had to be scored by the Congressional Budget Office (“CBO”) as costing less than \$1 trillion over the ten-year budgetary window. The task of

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<sup>61</sup> J. Mark Ramseyer, *Not-So-Ordinary Judges in Ordinary Courts: Teaching *Jordan v. Duff & Phelps, Inc.**, 120 Harv. L. Rev. 1199, 1208–09 (2007) (“In a second-best world, the right legal rule is not one that tries to get the right result every time. It is the rule Professor Richard Epstein attributes, in casual conversation, to the late Professor Walter Blum: a simple, easily implementable rule that gets the right result 95% of the time. In fact, even that approach may overestimate the abilities of real-world courts. In our badly flawed legal system, perhaps the right legal rule is not one that tries to get the right result 95% of the time. Perhaps it is a rule that leaves courts satisfied with a decent result 60% or 70% of the time. In either case, the easiest such rule to implement is . . . tell the plaintiff to get lost. . . . We live in a world with imperfect judges, costly and dishonest attorneys, and only moderately intelligent juries . . . [M]any cases are simply beyond the capacity of most real-world courts to handle cost-effectively.”). And that goes double for Congress.

<sup>62</sup> Robert Pear, *Making Exceptions in Obama's Health Care Act Draws Kudos, and Criticism*, N.Y. Times, Mar. 20, 2011, at A21, available at <http://www.nytimes.com/2011/03/20/health/policy/20health.html>; Jason Millman, *Number of Healthcare Reform Law Waivers Climbs Above 1,000*, Hill Healthwatch (Mar. 6, 2011, 4:38 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/147715-number-of-healthcare-reform-law-waivers-climbs-above-1000>. Ironically, a disproportionate share of the waivers appear to have been secured by enthusiastic proponents of PPACA. See Millman, *supra*; see also Kate Nocera, Weiner: Waiver Might Work for N.Y., Politico (Mar. 23, 2011), <http://dyn.politico.com/printstory.cfm?uuid=E237D0F7-D198-4A06-9F64-3DF700E014AB> (“A lot of people who got waivers were . . . people who are our friends.”).

selling PPACA to a skeptical public would also be substantially easier if it could somehow be scored by the CBO as deficit reducing (at least over the same budgetary window). As I have noted elsewhere, the Administration and Congress hit both of these targets by completely gaming the CBO scoring process.<sup>63</sup> If we assume for the sake of argument that Monahan and Schwarcz are correct in all of their particulars, then self-insured employers will respond to the gaming that gave us PPACA with some gaming of their own—making them and their employees better off and the taxpayers worse off, while also destabilizing health reform and undermining the willingness of the American public to continue underwriting progressive endeavors of this sort. What was that saying about no good deed going unpunished?

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<sup>63</sup> See Hyman, *supra* note 5, at 1A-18 (“After considerable reverse engineering, PPACA incorporated a wide array of design features explicable only in terms of their ability to game the CBO budget process and its ten year budget window. These included front-loading of the taxes; back-loading of the benefits, excluding the costs of fixing the Medicare physician payment system; assuming cuts in Medicare that are unlikely to materialize; assuming a future Congress will allow the 40% excise tax on high-value benefits to take effect when the current Congress deferred its effective date; and my personal favorite, counting the revenue from a new voluntary long-term care insurance program (CLASS Act) as deficit reducing in the first decade of PPACA, even though those amounts must be paid out in the second decade, and the program is so actuarially unstable that the Chief Actuary of [the Centers for Medicare and Medicaid Services] warned before the program even began collecting premiums that there was a ‘very serious risk that the problem of adverse selection will make the . . . program unsustainable.’”); see also Peter Suderman, *A Legacy of Budget Trickery*, N.Y. Post (July 25, 2010), [http://www.nypost.com/f/print/news/opinion/opedcolumnists/legacy\\_of\\_budget\\_trickery\\_8ct6pTyZoTHgKNhwerJdCM](http://www.nypost.com/f/print/news/opinion/opedcolumnists/legacy_of_budget_trickery_8ct6pTyZoTHgKNhwerJdCM) (“After initial drafts of the law proved far too expensive, ObamaCare’s authors knew they had to meet two criteria: Keep total spending for the first decade below a trillion dollars, and make sure the Congressional Budget Office reports the law will reduce the deficit. The White House and its allies in Congress succeeded, but only by piling on the gimmicks. So, for example, in order to keep the total first-decade cost down, ObamaCare delayed the bulk of the spending in the bill until 2014—meaning that the 2010-2019 10-year score only accounted for six years of spending. The official estimates also conveniently omitted hundreds of billions in additional spending that will be necessary to implement the law. According to an estimate by former CBO director Douglas Holtz-Eakin, running ObamaCare will eventually require \$274 billion in extra spending. Indeed, in a paper published in the June issue of the journal *Health Affairs*, Holtz-Eakin estimated that, once all the budget gimmickry is removed, the law will increase the deficit by more than half a trillion dollars—and that’s just in the first 10 years.”).