"Tomorrow" May Finally Have Arrived—The Patient Protection and Affordable Care Act: A Necessary First Step toward Health Care Equity in the United States

Renée M. Landers

Tomorrows

Tomorrows never seem to stay,
Tomorrow will be yesterday
Before you know.
Tomorrows have a sorry way
Of turning into just today,
And so . . . and so . . .

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")—the conclusion of a year-long legislative process aimed at addressing the well-documented deficiencies in access to and

---

1 © Renée M. Landers 2010.
2 Professor of Law and Faculty Director, Health and Biomedical Law Concentration, Suffolk University Law School. The author served as Deputy General Counsel in the Department of Health and Human Services from 1996–1997. This lecture is adapted from a presentation given as part of the program, The Health Care Reform Evolution: A Political, Legal, and Social Discussion, presented at Suffolk University Law School on February 25, 2010, coincidentally, the same day as President Obama’s health care summit with members of Congress. The program was sponsored by the Suffolk University Law School JOURNAL OF HEALTH & BIOMEDICAL LAW. Because The Patient Protection and Affordable Care Act was enacted subsequent to the program, the substance of this lecture has been updated accordingly. The author owes the structure of this commentary in part to Roger D. Donoghue, Esq., who served as moderator of the program for which these remarks were originally prepared. Audio of the program can be found online at http://www.jhbl.org/. The author appreciates the efforts of the Editorial Board of the Journal in organizing the discussion and in the preparation of this publication. In addition, the author expresses deep appreciation to Symposium Editor Lisa Keefer for her resourceful research assistance.

3 DAVID MCCORD, ALL SMALL: POEMS, 30 (Little, Brown & Co. 1986).
the delivery of health care services in the United States. This legislation signaled that the “tomorrow” that promised significant reform of the health insurance and health care delivery system may have arrived. In 2010, the Congress, or at least most Democrats in Congress, and the President moved beyond arguments that the legislation was not perfect and that some of its implications and impacts were unclear, including the costs of expanding insurance coverage to the uninsured and the extent to which reform would produce federal budget savings. This legislation recognizes that the “tomorrow” of perfect information, prescient and accurate foresight, and certainty of financial analysis would never arrive but that equity and practicality required action to improve access to health insurance before “tomorrows” become “today” and then “yesterdays” in the language of the David McCord poem. March 23, 2010 also marked the commencement of two very different processes. The first is the process that federal agencies and state governments will begin to prepare the regulatory changes necessary to implement the new law. Because the PPACA was enacted without a single Republican vote, the Republicans in Congress and other opponents are working on a parallel process to repeal or challenge the legislation in total or in significant respects.


This lecture will offer some thoughts to situate the PPACA in context—to describe the problems with current arrangements for health insurance and health care the legislation begins to address and areas where the legislation falls short. Each of the topics mentioned could be the subject of a full-length law review article, but this lecture just tries to set forth some of these issues in summary form. Critics of health care reform typically fault the PPACA for what it does not accomplish. Because of the complexity of health care financing, regulatory, and delivery systems, however, no single legislation could possibly address in a satisfactory or useful way everything that one might want to change about the status quo. An important accomplishment of this legislation will be that it takes the first step at addressing the problems. The quest for perfection in solving all the issues of cost and access plaguing the current system had become the enemy of taking constructive incremental steps in the right direction.

Evaluated by availability of health insurance coverage, access to adequate health care, and results achieved in relation to expenditures, the health care system in the United States is not performing well and may be getting worse as a result of the economic downturn. A recent article in Health Affairs projected that, absent some change in federal or state policies, fifty-two million non-elderly Americans will be uninsured by 2010, representing 19.2% of the non-elderly population. Workers losing their jobs are unable to afford their health insurance, and public sector safety nets, such as Medicaid, are inadequate due to strained state budgets. The cost of health insurance and health care undermines the financial health of families and the competitiveness of U.S. businesses. The wealthy and employed people with good health insurance, including members of Congress, have access to unparalleled quality in state of the art medical care, while millions of Americans do not receive basic health care at all or


devolve into bankruptcy to obtain the care they need.

One way to set realistic expectations for the PPACA is to be forthright about what this iteration of health reform actually is. The PPACA contains a number of provisions aimed at addressing access to insurance coverage. On an immediate level, the legislation creates a temporary subsidized insurance program for individuals who have been unable to obtain insurance because of pre-existing medical conditions. In addition, beginning six months from the signing date, the legislation prohibits insurers from excluding coverage for children based on pre-existing conditions. Insurance market reforms that would limit the ability of insurers to exclude coverage for pre-existing conditions, prohibit plans from establishing dollar limits on lifetime coverage and annual coverage, prohibit insurers from rescinding coverage except in instances of fraud or misrepresentation, and create health insurance exchanges to make it easier and more affordable for individuals to purchase non-group policies. The reforms will enable parents to retain adult children until age twenty-six on the parents’ health insurance plans. The legislation also restricts the ability of insurers to underwrite in

10 See Patient Protection and Affordable Care Act § 1101. This program will expire in 2014 when the American Health Benefit Exchanges become operational. Id.
12 See Public Health Service Act, 42 U.S.C.A. § 300gg (West 2010), amended by Patient Protection and Affordable Care Act § 2711.
13 See Public Health Service Act, 42 U.S.C.A. §§ 201–300ii-4 (West 2010), amended by Patient Protection and Affordable Care Act sec. 1001, § 2711 (prohibiting establishment of lifetime limits or unreasonable annual limits on dollar value of benefits).
15 See Patient Protection and Affordable Care Act § 1301 (defining qualified health plan).
16 See Public Health Service Act, 42 U.S.C.A. §§ 201–300ii-4 (West 2010), amended by Patient Protection and Affordable Care Act sec. 1001, § 2714. "Adult children who are married,
the individual and small group markets except on the basis of family structure, geography, age, and tobacco use within certain limits. To address the problem of underinsurance—having insufficient coverage for certain catastrophic conditions—the legislation authorizes the Department of Health and Human Services to establish essential health benefits requirements at different cost levels for health plans. The legislation also expands Medicaid eligibility to include individuals with incomes at or below 133% of the Federal Poverty Level and authorizes States to extend Medicaid coverage for all non-elderly individuals above 133% of the Federal Poverty Level. By 2014, individuals will be required to maintain insurance coverage or pay a penalty.

These and other provisions, when fully implemented, are expected to address many of the most severe problems of access to insurance. Most of the reforms will not become effective until 2014 which means that the public will not immediately experience the benefits of those aspects of the reforms. While the transition period of several years ensures a thoughtful process for crafting and implementing regulations and programs at the federal and state levels, this delay also creates the risk that reform could be repealed or weakened before its potential could be demonstrated.

however, will not be eligible to be covered under their parents’ insurance plans.” Id.
18 See Patient Protection and Affordable Care Act § 1302.
19 See id. at § 2001.
20 See id. at § 1501.

DeMint believes the bill eventually can be repealed, saying: “When people get the sense of what’s happening to them, the invasion of our privacy and our freedom, I think Americans are going to be increasingly alarmed. And I do think we can repeal it.”

Doing so probably will take more than one election, he says, but there is enough time because many parts of the bill don’t take effect in the next three or four years.
These reforms are essential components to addressing the problems of insurance coverage but do not address all the equity problems in the current system. One documented problem is the existence of racial and ethnic disparities in access to health care and in health status and outcomes. Enhancement of health insurance access through market reforms, individual mandates, and Medicaid expansion is a necessary, but not sufficient, component of an effort to reduce or eliminate disparities. The PPACA contains a fairly tepid requirement that any existing or new federal health programs collect data by race, ethnicity, primary language spoken, and other factors associated with health disparities and requires the Secretary of Health and Human Services to disseminate this information to relevant federal agencies. Another provision of the legislation seems aimed at reinvigorating programs that support the development and use of curricula for cultural competency and working with individuals with disabilities. The legislation creates grants to promote the activities of community health workers in providing culturally appropriate health education and information and contains extensive provisions aimed at expanding and training the health care workforce with some emphasis on providing greater access to services for underserved populations. While data collection and workforce development are also useful tools to address racial and ethnic equity, meaningful attention to disparities is on the list of matters that will require greater attention in future legislative efforts. In fact, some researchers have shown that policies promoting overall improvements in access may sometimes exacerbate existing disparities because disadvantaged populations are not as well situated to take advantage of improvements in access.

Id.


23 See Patient Protection and Affordable Care Act § 4302.

24 See id. at § 5307.

25 See id. at § 5313.

26 See id. at §§ 5101–5605 (addressing provisions related to health care workforce).

27 See Landers, supra note 22, at 49-50.
The PPACA has been much criticized for its ostensible failure to address the increasing cost of health care services and the increasing proportion of the GDP devoted to health care expenditures and to improve the quality of services provided. By requiring that individuals maintain health insurance coverage and by instituting market reforms to make that requirement realistic, the Congressional Budget Office has estimated that the legislation will reduce the federal budget deficit by $138 billion over the next ten years. In addition, the statute creates an Independent Payment Advisory Board charged with making recommendations to Congress for reducing the cost and improving the quality of the Medicare program. The legislation also contains numerous provisions aimed at improving the delivery of health care services. These initiatives, while modest, do continue the work of addressing the problem of cost and the constant effort to improve quality.

Criticisms that the legislation does not attack directly the rising costs of health care services are accurate. The PPACA represents a conscious choice to improve access to health insurance and health care first and to institute policies to reduce costs and improve quality in the future. To the extent that the PPACA, in requiring that individuals maintain health insurance and providing market reforms and subsidies to make acquisition of insurance more affordable, follows the health reform legislation enacted in Massachusetts in 2006, the PPACA also seems to be following the Massachusetts decision to address costs after expanding access to insurance. Massachusetts has been diligent in moving to the next stage in addressing costs. Following a six-month process, the Massachusetts Special Commission on the Health Care Payment System issued recommendations aimed at restructuring health care payment methodologies in the state in July 2009. In addition, the Massachusetts

---

29 See Patient Protection and Affordable Care Act § 3403 (stating purpose is to “reduce the per capita rate of growth in Medicare spending”).
30 See, e.g., id. at §§ 3501-3502 (enabling Director to “identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices”).
Division of Insurance recently rejected proposed rate increases from numerous health plans using infrequently exercised authority. The Massachusetts approach so far has demonstrated success in achieving improvements in the rates of insurance. Now, policy makers and officials have turned their attention to addressing costs and quality issues. A similar approach could unfold on the federal level.

No nation has "solved" the problems of health care delivery and cost for all time. The issues are far too complex and evolving for any system to make that claim. Take Sweden, for example. That country has certain advantages over the U.S.—among them a relatively homogeneous population and a longstanding commitment to universal health coverage. As in every system, however, controlling costs is a concern, and Sweden recently began converting pharmacies from government monopoly control to a combination system of private and government ownership. This change in Sweden is

---


34 See Victor R. Fuchs, National Health Insurance Revisited, in WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 191, 199 (1998) ("The relatively homogeneous populations of Scandinavia not only enjoy universal health coverage for health care but also have many other egalitarian social programs.").

but one illustration of the need for all governments to evaluate regularly what is working and what needs improvement for cost, quality, or equity reasons regardless of the basic structure of the system.

This example from Sweden also illustrates the danger in attaching broad labels to complex policy. Because of government-sponsored universal access, some would label the Swedish system “socialized” medicine even though that system involves market elements. The U.S. Medicare program could be called a “socialized” program because the federal government controls and pays for its benefits. Medicare is not perfect, but it basically works. Hardly anyone criticizes Medicare as “socialized” anymore because it is essential to the financial security of the elderly and their families. For example, in the

---


recent debates over the PPACA, Republicans offered the most vocal objections to any changes in the Medicare program. Even with government control, people make their own health care decisions.

Private markets have failed to provide universal access to quality health care, but have made the insurance, pharmaceutical, and segments of the health care services industries wealthy and powerful. An increased government role to address the real problems of the uninsured and underinsured will not necessarily change private market insurance with which people are now basically satisfied. Since the adoption of recent health reforms, Massachusetts has experienced no decline in employer coverage because of the existence of expanded public health insurance programs or subsidies for insurance for lower and moderate-income residents.

These facts lead to the conclusion that the opponents of health reform, in the end, care more about form than substance, more about labels and preserving the status quo than the health care that ordinary people in the United States actually receive. If health reform improves a system that fails so many—recognizing that health care will

---


40 See Sharon Long & Karen Stockley, Massachusetts Health Reform: Employer Coverage from Employees' Perspective, 28 HEALTH AFF. w1079, w1085 (Nov. 1, 2009), http://content.healthaffairs.org/cgi/reprint/28/6/w1079. Long and Stockley found [t]here is no evidence that employers are dropping coverage or tightening eligibility for coverage among their workers. There is also no evidence that the care available under employer-sponsored coverage has deteriorated. In fact, workers in Massachusetts rated the scope of services and quality of care available under their employer coverage more highly under health reform than before.
always be a work in progress—it should not matter whether the methods chosen could be labeled “socialized” or “market” as long as the reforms work.

Finally, opponents of health care reform have raised a number of constitutional objections to the new statute. The attorneys general of thirteen states joined together to challenge several components of the legislation in a suit filed the day after the President signed the bill into law. The Attorney General of Virginia filed a separate challenge. The suit involving thirteen states alleges that the expansion of Medicaid and the role contemplated for the states in creating insurance exchanges violates the Tenth Amendment to the United States Constitution and exceeds Congress’s power under the Commerce Clause because it requires the states to take extensive actions and to commit resources and personnel to a federal program in violation of the anti-commandeering principle. In addition, the suit challenges the validity of the tax on persons who do not have health insurance on the grounds that the statute exceeds Congress’s power to tax and spend. The insurance mandate is also challenged on the grounds that it exceeds congressional authority under the Commerce Clause in that it interferes with the ability of the states to protect their citizens from federal intrusion.

Id.


45 See id. at 19-20.
If the Supreme Court follows existing precedents, it is unlikely that these challenges will be successful.\(^4\) Two aspects of the health reform legislation have the potential to raise federalism concerns and questions about whether the requirements violate the Tenth Amendment.\(^4\) One is the expansion of the Medicaid program and the other is the requirement that states create insurance exchanges to make the process of purchasing insurance more transparent and affordable. While historically the Tenth Amendment has not served as a meaningful restraint on federal power, recently the Supreme Court invalidated statutes where a state’s participation in administering a federal program was required.\(^4\) Regarding the Medicaid expansion, it is true that expanding the eligibility criteria to require states to cover all persons having incomes at or below 133% of poverty will cost the states more in funding at a time when state resources are under significant pressure.\(^4\) If these new Medicaid requirements and the requirement to develop exchanges are tied to a state’s decision to accept federal funding for participation in the federal program, the Supreme Court is not likely to find those two precedents applicable.\(^5\) To the extent that the requirements of the PPACA impose requirements on state and local governments identical to the requirements imposed on other employers, Congress is probably justified. In Garcia v. San Antonio Metropolitan Transit Authority,\(^5\) the Supreme Court held that state and local government employees are subject to federal minimum wage and maximum hour laws.\(^5\)

Although it is not possible within the framework of this lecture to present an exacting analysis of these issues in order to meet the challenges raised in the two lawsuits, the Supreme Court’s Commerce Clause jurisprudence would seem to give


\(^{4}\) The Tenth Amendment provides: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” U.S. CONST. amend. X.

\(^{4}\) See Printz, 521 U.S. 898, 926 (1997) (invalidated Brady handgun Violence Prevention Act because state and local law enforcement officials were required to conduct background checks on prospective handgun purchasers); New York v. United States, 505 U.S. 144, 176 (1992) (invalidating federal law that required states to take title to radioactive waste not properly handled within a certain time period and created state liability for damages caused by the waste).


\(^{5}\) See, e.g., South Dakota v. Dole, 483 U.S. 203, 210-11 (1987) (upholding federal statute preventing states from receiving federal highway funds unless states raised the drinking age to 21).

\(^{5}\) 469 U.S. 528 (1985).

\(^{5}\) Id. at 555-56.
broad discretion to Congress in exercising power to regulate the availability and cost of health insurance.\footnote{The Commerce Clause gives Congress the power "To regulate Commerce . . . among the several States." U.S. CONST. art. I, § 8, cl. 3.} The recent case of \textit{Gonzales v. Raich}\footnote{545 U.S. 1 (2005).} illustrates the broad interpretation the Supreme Court has given Congress's authority under the Commerce Clause. In that case, the Court held that Congress could prohibit the production and possession of small amounts of marijuana for medical purposes based on its Commerce Clause authority because of the impact of such activity on the national markets.\footnote{\textit{Id.} at 19. The \textit{Raich} holding is similar to the result in the World War II-era decision involving wheat produced for home consumption, where the Court ruled that the activity's effect on the interstate market subjected the activity to congressional regulation under the Commerce Clause. See \textit{Wickard v. Filburn}, 317 U.S. 111, 128 (1942).} The insurance mandate and the exchanges to regulate the markets for health insurance established in the PPACA certainly affect economic activity and have an impact on the interstate market for health insurance and health care services.\footnote{See \textit{id.} at 561.} Since 1937, the Supreme Court has limited the reach of congressional authority under the Commerce Clause only when Congress has sought to regulate non-economic activity. In \textit{United States v. Lopez}\footnote{514 U.S. 549 (1995).} for example, the Court invalidated a federal law requiring gun-free zones around public school facilities because the statute was "a criminal statute that by its terms has nothing to do with 'commerce' or any sort of economic enterprise."\footnote{See \textit{id.} at 561.} Similarly, in \textit{United States v. Morrison}, the Supreme Court ruled unconstitutional the provisions of the Violence Against Women Act that created civil liability for violent crimes motivated by gender because the nature of the conduct at issue was noneconomic.\footnote{529 U.S. 598 (2000).} Unless the Supreme Court decides to impose new limitations on congressional authority, the PPACA is likely to survive constitutional challenges on these grounds.

In the context of the debate of the PPACA, the issues of federal expenditures for abortion services and for alternative forms of health care such as spiritual care came to the fore.\footnote{See generally Ed Hornick, \textit{Abortion Issue Seen as Key to Health Care Reform Package}, CNN, Mar. 22, 2010, http://edition.cnn.com/2010/POLITICS/03/22/abortion.health.care.vote/index.html (analyzing how issue of abortion affected health care reform efforts).} By agreeing to sign an Executive Order affirming that the PPACA maintained "current Hyde Amendment restrictions" governing federal policy on funding...
abortion policy would derail the larger health reform initiative.\textsuperscript{62} At the same time, the statute provided funding for abstinence-only sex education programs.\textsuperscript{63} Proposals to fund spiritual care did not survive the legislative process.\textsuperscript{64} The real policy disagreements over the appropriateness and efficacy of these federal policies no doubt will be the subject of future debates as health care reform is implemented.

In enacting the PPACA, the nation has taken one big step beyond the fear and uncertainty that prevented major health care reform since the creation of the Medicare and Medicaid programs in 1965. It remains to be seen whether these advances can be sustained through the process of implementation and the inevitable revisions that will become necessary and whether the programs created will survive legal challenge. It is possible that the PPACA will become the first of many continuing efforts to realize the promise of a health care system that provides some meaningful level of health care to all citizens at a cost that individuals, employers, and the taxpayers are able to afford.


\textsuperscript{63} See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2954, 124 Stat. 119 (2010). This section is entitled “Restoration of Funding for Abstinence Education,” and while the statute does, in fact, restore funding for abstinence education for fiscal years 2010 through 2014, sex education curricula will include both the teaching of abstinence and contraception in programs funded by the PPACA. See id. at § 2953 (where sexual-education programs will include the teaching of “both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS”).