The Affordable Care Act: Moral Hazard, Adverse Selection, Challenges, Alternative Proposals, and Amendments in Health Insurance Law

Paige Ross[1]

The Patient Protection and Affordable Care Act (ACA), or "Obamacare," is a comprehensive health care reform law passed in March 2010 with three primary goals: make affordable health insurance available to more people, expand the Medicaid program to cover all adults with income below 138% of the FPL (federal poverty level), and support innovative medical care delivery methods designed to lower the costs of health care generally.[2]

The ACA works to protect people in numerous ways including: requiring insurance plans to cover people with pre-existing health conditions (including pregnancy) without charging more, providing free preventive care, giving young adults more coverage options, ending lifetime and yearly dollar limits on coverage of essential health benefits, holding insurance companies accountable for rate increases, and making it illegal for health insurance companies to cancel your health insurance just because you become sick.[3] The law also allocates additional benefits and rights to mental health and substance abuse services as well as the right to appeal a health plan decision.[4]

The ACA also instituted several policies to stabilize premiums and encourage enrollment among healthy individuals including such things as tax credits and cost-sharing subsidies for those who would otherwise remain uninsured.[5] The design of the law's premium tax credits makes

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[1] J.D. Candidate, 2022, University of Nebraska College of Law.
[2] *Affordable Care Act (ACA)* https://www.healthcare.gov/glossary/affordable-care-act/.
[3] *Health Coverage Rights and Protections* https://www.healthcare.gov/health-care-law-protections/.
[4] *Id*.
[5] Christine Ebner & Evan Saltzman, *Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage*, RAND HEALTH QUARTERLY (2015) https://www.rand.org/pubs/periodicals/health-quarterly/issues/v4/n4/04.html.

recipients relatively immune to premium increases which reduces the impact of premiums on enrollment.[6] The individual mandate simultaneously imposes monetary penalties on individuals who choose not to enroll, which phase in over time.[7]

Additionally, unlike some state health insurance rating systems, the ACA does not do a full community rating (where all enrollees are charged the same premium regardless of age).[8] Further, risk adjustment, reinsurance, and risk corridors provisions included in the law may further stabilize the market by protecting insurers from potential losses that could occur due to an uncertainty about the health of the individuals enrolling.[9] Reinsurance is a temporary program that provides payments to plans in the event the enrollee has an unusually high expenditure (> $45,000).[10] Risk corridors limit excessive gains or losses that might occur if plans inaccurately set premiums.[11] The ACA's permanent risk adjustment program transfers funds from plans with low-risk enrollees to plans with high-risk enrollees which ensures that plans are viable even if they attract a more sick population. This also helps reduce insurer incentive to "cherry pick" low-cost enrollees.[12]

The ACA has allowed for greater access to healthcare for a vast number of Americans, especially those with certain long-term health issues that are likely to be expensive. One study by Davidoff et al found that the uninsured rate for cancer survivors decreased from 12.4% to 7.7% after the implementation of the ACA.[13] The authors conclude that ACA implementation was associated with large coverage gains in targeted expansion groups, including cancer survivors, but

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[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] Amy J. Davidoff et al., *Changes in Health Insurance Coverage Associated with the Affordable Care Act among Adults With and Without a Cancer History*, MEDICAL CARE JOURNAL, AMERICAN PUBLIC HEALTH ASS'N (Mar. 2018), 56(3): 220-227, 220 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6105312/.

additional progress is needed. Prior to the ACA however, an estimated 14.7% of cancer survivors below 65 years of age (~1.4 million) lacked insurance.[14]

Following the implementation of the ACA, several coverage provisions implemented in January 2014 were intended to increase demand, and improve access to health insurance, including those for cancer survivors.[15] The ACA established health insurance Marketplaces which offer individual plans with standard levels of coverage and provide income-based tax credits to reduce premiums and cost-sharing subsidies.[16] The ACA also prohibited basing premium prices on health history in many private insurance markets and expanded Medicaid to adults without dependent children at higher incomes.[17]

While the ACA has afforded a percentage of America's population greater benefits when it comes to health care and health insurance, the act remains controversial today especially along political and racial lines. One of the boldest original mechanisms for reducing racial inequities under the ACA was the expansion of Medicaid.[18] If Medicaid expansion had proceeded as originally planned, this patchwork policy design would have been augmented with a more standardized national approach applied to all Americans at or below 138% of the federal poverty line.[19] While these expansions are not explicitly race-based in nature, the population of Americans living in or near poverty are disproportionately Black or Latino (20% of Medicaid beneficiaries

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[14] *Id*. at 2.
[15] *Id*.
[16] *Id*.
[17] *Id*.
[18] Jamila Michener, *Race, Politics, and the Affordable Care Act,* J HEALTH POLIT POL'Y LAW, 547-566, (Aug. 1, 2020) https://doi.org/10.1215/03616878-8255481.

[19] *Id*.

are Black and 30% are Latino). Therefore, the main beneficiaries of the ACA as originally structured were those in or near poverty, which are usually racial and ethnic minorities.

A major issue to address with health insurance in any context, including the ACA, is that of moral hazard. Moral hazard refers to the tendency of any insured party to exercise less care to avoid an insured loss than would be exercised if the loss were not insured.[20] It can result from the policyholders having better information about their actual care levels after coverage is purchased. Additionally, moral hazard requires that the insurer cannot perfectly monitor the policyholder's level of care after the purchase of insurance. Moral hazard is more likely to occur if a behavior does not involve a policyholder's own risk.

In the context of health insurance, the term "moral hazard" is used to capture the idea that insurance coverage, by lowering the marginal cost of care to the individual (commonly referred to as the out-of-pocket cost), may increase healthcare use.[21] It has also been postulated that health insurance may induce individuals to exert less effort in maintaining their health because health insurance covers some of the financial costs that would be caused by poor health behaviors.[22] This may lead individuals to have less incentive to avoid bad health behaviors and they may exercise less, eat less healthy foods, and abuse or use drugs or other substances such as alcohol and cigarettes.[23] However, this "*ex ante* moral hazard" has received little empirical support.

The greater focus of moral hazard literature in health insurance is what has been referred to as "*ex post* moral hazard."[24] So-called "*ex post* moral hazard" refers to the responsiveness of

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[20] KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION: CASES AND MATERIALS (7TH ED. 2020) AT 5.
[21] Liran Einav & Amy Finkelstein, *Moral Hazard in Health Insurance: What We Know and How We Know It*, J. OF EUROPEAN ECON. ASS'N 957-982, 958 (2018) https://academic.oup.com/jeea/article/16/4/957/4992078.
[22] *Id*.
[23] *Id*.
[24] *Id*. at 960.

consumer demand for healthcare to the price she has to pay for it, conditional on her underlying health status.[25] Health insurance is valuable because it creates a vehicle for transferring consumption from when one is healthy to when one is sick.[26] However, demand for healthcare is not analyzed like other goods, as demand for healthcare is determined by "needs" rather than economic factors.[27]

Much of the moral hazard present in healthcare cannot be analyzed like the goods people freely purchase on the market because most of healthcare costs are attributed to necessary medical procedures rather than elective treatments. Under the ACA, particular scrutiny has been given to moral hazard problems. In one study by Daniele Corso, the analysis showed that while disparities were reduced between social classes, *ex-ante* moral hazard is a real problem with the ACA since individuals covered by public insurance tended to abuse the public service.[28] According to the results of this study, those who benefited from the Act reduced their preventive behaviors: there was an increase in smoking and a decrease in level of physical activities.[29]

Additionally pertinent to the discussion of moral hazard in the context of the ACA is the potential income effects from gaining free or subsidized coverage which could influence behaviors in potentially conflicting ways.[30] Consumers could choose to spend money previously budgeted for direct purchase of medical care or associated medical costs on products adverse to their health such as alcohol, cigarettes, and junk food, or alternatively, on healthier foods and gym

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[25] *Id*.
[26] *Id*.
[27] *Id*. at 962.
[28] Daniele Corso, *Drawback and Aftermath of the Affordable Care Act: Ex-Ante Moral Hazard and Inequalities in Health Care Access*, J PUB. HEALTH RES., 10(4): 2,135, Oct. 26, 2021, published online May 5, 2021 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8567089/
[29] *Id*.
[30] Charles Courtemanche et al., *Effects of the Affordable Care Act on Health Behaviors after Three Years*, 1-36 (Feb. 2018) https://clas.ucdenver.edu/economics/sites/default/files/attached-files/aca_behaviors.pdf.

memberships.[31] In another study, this increase in access as well as *ex ante* moral hazard appeared to be corroborated. For a full sample of non-elderly adults, the ACA increased well-patient checkups, pap and HIV tests, mammograms, and risky drinking in non-Medicaid-expansion states, with the effects as statistically indistinguishable in Medicaid expansion states.[32] There was also evidence of *ex ante* moral hazard in the ACA's third year illustrated by greater smoking and less exercise.[33]

The study stated that while a majority of the results obtained for risky behaviors were statistically insignificant, there was relatively robust evidence that the ACA increased risky drinking behaviors.[34] The study concluded that while early studies such as this one can be helpful in evaluating the ACA's impact in the immediate, short-term with regard to *ex ante* moral hazard and risky, unhealthy behaviors, "any comprehensive evaluation of the ACA would have to take into account effects on a wide range of other outcomes, including overall health, financial protection, health care expenditures, fiscal costs, employment, and wages."[35]

Some scholars argue that moral hazard does not exist in healthcare. According to Malcolm Gladwell, moral hazard in health insurance is a myth and a "singularly American obsession that has created our singular lack of universal coverage."[36] Gladwell writes, "The moral hazard argument makes sense…only if we consume healthcare in the same way that we consume other goods, and to [some] this assumption is plainly absurd. We got to the doctor grudgingly, only

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[31] *Id*. *See also* Kosali Simon, Aparna Soni, & John Cawley, *The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions*, 36 JOURNAL OF POLICY ANALYSIS AND MANAGEMENT 390-417 (2017) (Explaining that income effects from gaining free or subsidized coverage could influence behavior in conflicting ways by incentivizing *less* healthy behaviors as opposed to *more* healthy behaviors).
[32] *Id*. at 4.
[33] *Id*.
[34] *Id*. at 20.
[35] *Id*.
[36] *Supra* note 20.

because we're sick."[37] However, many studies and various literature on the subject have illustrated that such moral hazard irrefutably exists and is present in healthcare. However, the long-term moral hazard impacts (both *ex ante* and *ex post*) will remain somewhat ambiguous when analyzed within the ACA as these developments may take more time to see reflected statistically.

Yet another major issue with the ACA and health insurance is that of adverse selection. Adverse selection is a potential market failure that arises from the possibility that policyholders may have better information than insurers regarding their risk levels, but the key distinction between the two is the timing of the information.[38] Adverse selection can result from the policyholders having better information about their risk level at the time they purchase coverage.[39] This can occur when, at the time policyholders apply for insurance, they know their risk of a covered loss better than insurers.[40] The migration of low-risk policyholders out of the insurance pool will result in the average degree of risk posed by the insurer's policyholders rising, forcing the insurer to raise prices which can restart the cycle of adverse selection.[41]

According to Shi et al, adverse selection occurs in insurance marketplaces where information asymmetry between the buyer and the seller leads to suboptimal pricing, efficiency loss, and even market failure.[42] A health insurance seller typically knows less than individual buyers about their health status and subsequent health care expenditures and therefore it is unsurprising that adverse selection has been found in a variety of types of health plans.[43] This

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[37] Malcolm Gladwell, *The Moral Hazard Myth*, THE NEW YORKER (Aug. 29, 2005) https://www.newyorker.com/magazine/2005/08/29/the-moral-hazard-myth.
[38] Abraham & Schwarcz, *supra* note 19 at 6.
[39] *Id*.
[40] *Id*.
[41] *Id*. at 7.
[42] Lu Shi et al., *Does Awareness of the Affordable Care Act Reduce Adverse Selection? A Study of the Long-Term Uninsured in South Carolina*, PUBMED (Oct. 3, 2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798667/.
[43] *Id*. at 1.

adverse selection present in health insurance impacts the stability of these plans. According to David M. Cutler and Richard J. Zeckhauser, adverse selection can lead to three classes of inefficiencies: prices to participants do not reflect marginal costs, hence on a benefit-cost basis individuals select the wrong health plans; desirable risk spreading is lost; and health plans manipulate their offerings to deter the sick and attract the healthy.[44]

The impacts of adverse selection in health insurance can be felt across the board when it comes to effects. Adverse selection can negatively influence health insurance companies financially, leading to fewer insurers to choose from in the market or higher rates for those who purchase a policy.[45] Additionally, as healthier individuals drop out of the health insurance marketplace, those insured have a pool that contains more high-risk policies.[46] As a result, insurance companies would be forced to pay out a significant portion of claims as compared to the number of policies in action because a disproportionately high number of insured people are utilizing more health care. Lastly, a lack of healthy people in the pool of insureds can reduce the total amount of premiums the insurance company receives, forcing the company to drive up rates to make up the difference.

In the context of the ACA, the purpose behind the so-called "individual mandate" was to overcome adverse selection among insurance subscribers by legally requiring individuals to purchase health insurance to avoid a penalty.[47] Adverse selection indicates that less healthy people could be more likely to sign up for a given premium listed in the marketplace, driving up the

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[44] David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, 1-32, 2 *in* FRONTIERS IN HEALTH POLICY RESEARCH (Jan. 1998) https://www.nber.org/system/files/chapters/c9822/c9822.pdf.

[45] *Adverse Selection in Insurance: Know How It Works, The Effects and Solutions*, PLUM (Apr. 9, 2021) https://www.plumhq.com/blog/adverse-selection-in-insurance.

[46] *Id.*

[47] *Id.*

premium price.[48] This is of particular concern as pertains to the ACA because the guaranteed issue and community rating might contribute to the issue of adverse selection when people sign up for insurance plans in the federally facilitated marketplace.[49]

According to the RAND Corporation, the ACA's tax credits and eliminating the individual mandate both increase premiums and reduce enrollment in the individual market.[50] However, these same key features also help to protect against adverse selection and stabilize the market by encouraging healthy people to enroll, and the tax credit shields subsidized enrollees from premium increases.[51] The RAND Corporation speculates that if alternative subsidy arrangements were in place that shift more risk to enrollees (i.e.: flat vouchers) the vulnerability of the market to adverse selection would increase and the market's stability would markedly decrease. Additionally, as of 2015, the RAND Corporation did not find any significant impact on individual market premiums which were only moderately sensitive to young adults' enrollment. This ensures that the market's stability is not dependent on young adults to make up a set share of the enrollees.[52]

Various solutions have been posed to mitigate the impacts of adverse selection and some of these could very well be seen in amendments to the ACA. One way for insurance companies to avoid adverse selection is by grouping higher risk individuals and charging them higher premiums.[53] These premium rates could be based on a variety of factors including: clients' health condition, age, weight, medical history, hobbies, occupation, and lifestyle risks (i.e.: smoking, obesity, and diabetes).[54] These factors influence a person's health and longevity prospects and can

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[48] *Id*. at 1-2.
[49] Chad Mulvany, *Insurance Market Reform: The Grand Experiment*, HEALTHC FINANC. MANAGE. 82-88 (Apr. 2013) https://pubmed.ncbi.nlm.nih.gov/23596836/.
[50] Ebner & Saltzman, *supra* note 4.
[51] *Id*.
[52] *Id*.
[53] *Supra* note 44.
[54] *Id*.

determine the company's potential to pay a claim. In the underwriting process, the company should use such factors to decide whether to give a potential client an insurance policy and at what premium level the company should charge.[55]

The ACA has been legally challenged in a variety of ways including, plainly, the act's constitutionality. The act has also become a highly partisan issue which ignites fierce debate on both sides of the political aisle. One of the most controversial elements of the ACA to be litigated pertained to the act's so-called "individual mandate." This provision is titled the "Requirement to Maintain Minimum Essential Coverage" and is sometimes referred to as the "minimum coverage requirement" or the "minimum essential coverage requirement."[56] This minimum coverage provision was contained by amending the tax code, stipulating that by 2014, non-exempt individuals who failed to purchase and maintain a minimum level of health insurance must pay a tax penalty.[57]

In applying relevant constitutional law principles, a court must first determine exactly what class of activities is regulated under the minimum coverage requirement.[58] Proponents of the narrow view hold that the mandate regulates conduct in the national health insurance market by forcing individual, private citizens to purchase a minimum level of coverage.[59] These proponents argue that by doing so, the government is impermissibly infringing on the rights of private citizens to choose whether or not to buy health insurance.[60]

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55 *Id*.
56 26 U.S.C.A. § 5000A.
57 https://www.oyez.org/cases/2011/11-393 discussing Sebelius.
58 Thomas More Law Ctr. v. Obama, 651 F.3d 529, 542-543, (6th Cir. 2011).
59 *Id*.
60 *Id*.

Those in America who lean more conservative tend to believe that this government interference in individual decision-making is patently unconstitutional. Those who are more progressive see this as an effective way to help ensure that those in need of health insurance under the ACA are able to afford it. Proponents of a broader view of the mandate contend that it regulates activity in the comprehensive arena of the national health care market, because the overarching purpose of the ACA is to improve access to quality health care for all Americans.[61] This tension goes to the heart of the political controversy behind the individual mandate portion of the ACA and why it was quickly litigated in *National Federation of Independent Business v. Sebelius*.

In *Sebelius*, twenty-six states, several individuals, and the National Federation of Independent Business brought suit in Federal District Court, challenging the constitutionality of the individual mandate and the Medicaid expansion. The plaintiffs argued that: (1) the individual mandate exceeded Congress' enumerated powers under the Commerce Clause; (2) the Medicaid expansions were unconstitutionally coercive; and (3) the employer mandate impermissibly interfered with state sovereignty.[62] Chief Justice Roberts, joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan concluded that the individual mandate penalty is a tax for the purposes of the Constitution's Taxing and Spending Clause and is a valid exercise of Congressional authority.

The Court also found that the payment was not coercive, is not limited to willful violations like fines for unlawful acts, and is collected by the Internal Revenue Service by normal means.[63] The dissent, written by Justices Scalia, Kennedy, Thomas, and Alito argued that because Congress

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[61] *See* Matthew R. Farley, *Challenging Supremacy: Virginia's Response to the Patient Protection and Affordable Care Act*, 45 U. RICH. L. REV. 37, 37-38 (2010) cited by Arthur Nussbaum, *Can Congress Make You Buy Health Insurance – The Affordable Care Act, National Health Care Reform, and the Constitutionality of the Individual Mandate*, 50 DUQ. L. REV. 411, 413 (2012) https://dsc.duq.edu/dlr/vol50/iss2/7.
[62] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).
[63] *Id*.

characterized the payment as a penalty, to instead characterize it as a tax would amount to rewriting the Act.[64] The 5-4 majority upheld the individual mandate as constitutional under the Constitution's Taxing and Spending Clause. While the Court would hold the individual mandate to be constitutional under *Sebelius*, further legal issues would continue to arise pertaining to this and other elements of the ACA.

According to Peter Smith of George Washington Law School, "The Act's opponents have pressed their attack by arguing that the individual mandate exceeds Congress's affirmative powers as a matter of federalism doctrine…More strikingly, the particular limitation that the opponents of the mandate have urged – that Congress lacks the power to regulate "inactivity" under the Commerce and Necessary and Proper Clauses."[65] However, "if indeed such mandates are problematic because they interfere with individual liberty, then there is no obvious reason why they would be any more problematic when imposed by the federal government than they are when imposed by the states."[66] Therefore, opponents of the individual mandate likely have a weak case on federalism grounds to legally challenge the ACA.

Two other Supreme Court cases have challenged various aspects of the ACA. In *King v. Burwell*, the plaintiffs argued that individuals who live in states using the federally facilitated exchange (or HealthCare.gov) are not eligible for health insurance subsidies because the ACA states subsidies are available for health plans purchased through, "an Exchange established by the state."[67] The legal question in *Burwell* was whether states opting to use HealthCare.gov rather than

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[64] *Id*.
[65] Peter J. Smith, *Federalism, Lochner, and the Individual Mandate*, 91 BOSTON UNIV. L. REV. 1723-1746, 1737 (2011), http://www.bu.edu/law/journals-archive/bulr/documents/smith_000.pdf.
[66] *Id*. at 1744.
[67] *Legal Cases and State Legislative Actions Related to the ACA*, NAT'L CONFERENCE OF STATE LEGISLATURES (NCSL) Jun. 29, 2021 https://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx. *See also* King v. Burwell, 135 S. Ct. 2480 (2015) (Holding that the provisions of the Patient Protection and Affordable Care

operating their own exchange were considered "an Exchange established by the state."[68] In 2015, the Court ruled that consumers purchasing health insurance through HealthCare.gov are eligible for health insurance subsidies, and that ruling otherwise would destabilize the health insurance marketplaces – the opposite intent of the federal health law.[69]

In *California v. Texas*, eighteen states (and two individuals) filed a lawsuit in February 2018 arguing that, because federal lawmakers reduced the mandate's "shared responsibility payment" to $0 through the 2017 Tax Cuts and Jobs Act, the individual mandate is unconstitutional.[70] The individual mandate was repealed by the Tax Cuts and Jobs Act of 2017, eliminating the fine imposed on people without health care coverage beginning in 2019.[71] The plaintiffs in *California v. Texas* based their argument on the Court's 2012 ruling in *Sebelius* that the individual mandate was a tax. The Court ruled in June 2021 that both the individual and state plaintiffs lacked standing to challenge the law in court because the plaintiffs failed to show a personal injury that was "fairly traceable" to the $0 individual mandate.[72]

In practice, the ACA has had the goals of making health insurance and healthcare more accessible and affordable to both racial and ethnic minorities, and to the poorer classes. According

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Act (ACA) unambiguously made federal tax credits available to individuals enrolled in an insurance plan through a Federal Exchange in their states).

[68] *Id*.

[69] *Id*.

[70] *Legal Cases and State Legislative Actions Related to the ACA*, NAT'L CONFERENCE OF STATE LEGISLATURES (NCSL) Jun. 29, 2021 https://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx. *See also* California v. Texas, 141 S. Ct. 2104 (2021) (Considering issues of a live controversy and standing pertaining to a challenge to the ACA due to the individual mandate injuring the individual plaintiffs by requiring them to buy insurance that they did not want, and the state plaintiffs, by increasing their costs of complying with the reporting requirements that accompanied the individual mandate. Additionally, examining whether the individual mandate was unconstitutional because it could no longer be read as a tax).

[71] Sean Ross, *The Affordable Care Act Affects Moral Hazard in the Health Insurance Industry*, INVESTOPEDIA, July 13, 2021 https://www.investopedia.com/ask/answers/043015/how-does-affordable-care-act-affect-moral-hazard-health-insurance-industry.asp.

[72] *Legal Cases and State Legislative Actions Related to the ACA*, NAT'L CONFERENCE OF STATE LEGISLATURES (NCSL) June 29, 2021 https://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx.

to Jamila Michener, "On the one hand, health care politics became more deeply racialized during the presidency of Barack Obama and has remained so. On the other hand, ACA policy was a harbinger of racial promise."[73] Additionally, Michener remarks that the ACA "had the potential to truly alter the landscape of racial and ethnic health disparities in the United States."[74]

The ACA did reduce ethnic/racial disparities in health insurance coverage, access to care, and health care utilization.[75] The reduction in insurance coverage gaps was one of the most salient ways that the ACA had a salutary effect on racial inequity.[76] Between 2013 and 2017, the coverage gap between Black and white Americans dropped from 11.0% to 5.3%.[77] Similarly, during the same period, the coverage gap between Hispanics and non-Hispanic whites dropped from 25.4% to 16.6%.[78]

However, despite the gains and successes the ACA created in racial/ethnic disparities, racial imbalances and inequities in health care access and quality persist in the post-ACA era. Michener argues that even the most salient inequality-reducing feature of the ACA – the Medicaid expansion – has endured politically induced variation, attenuating its effectiveness at diminishing racial disparities, and that many features of the ACA that explicitly target racial disparities have proven unstable or limited because their implementation has been contingent on political conditions.[79]

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[73] Michener, *supra* note 17.
[74] *Id*.
[75] *Id*.
[76] *Id*.
[77] *Id*. (citing Ajay Chaundry et al., *Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?*, COMMONWEALTH FUND 1-11 (Aug. 2019)).
https://collections.nlm.nih.gov/master/borndig/101755573/Chaudry_did_ACA_reduce_racial_disparities_ib_v3.pdf.
[78] *Id*.
[79] *Id*.

The Hispanic population in America saw the highest initial uninsured rate and has experienced the greatest gains in health insurance coverage after the enactment of the ACA.[80] Additionally, Hispanic noncitizens (such as green card holders) also made gains in their insurance coverage, although this group did not qualify for Medicaid or for subsidies.[81] The study further found that all groups gained from the ACA's expansions of public insurance coverage and private insurance coverage. Private coverage grew the most among Black non-Hispanics and among Hispanics.[82]

Further, coverage gains were much greater in states that chose to participate in the Medicaid expansion than in those that did not and this had a disproportionately positive impact for the Hispanic population. Overall, the study found evidence for a link between expansion in access to coverage and equity in receipt of that coverage.[83] Gaps in insurance coverage among racial and ethnic groups narrowed extensively after the implementation of the ACA coverage expansions, and most especially between 2013 and 2016.[84]

Yet another major goal of the ACA was to make health insurance coverage more widely available to those who fell under the FPL. Many of the studies conducted about healthcare coverage under the ACA have confirmed that the ACA reduced income inequality in the U.S. in terms of accessing health insurance. According to Matthew Buettgens and Fredric Blavin, the ACA reduced income inequality overall and this reduction in inequality was felt in greater proportion

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[80] Ajay Chaudry et al., *Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?*, THE COMMONWEALTH FUND, 1-11 (Aug. 2019) https://collections.nlm.nih.gov/master/borndig/101755573/Chaudry_did_ACA_reduce_racial_disparities_ib_v3.pdf.
[81] *Id*. at 2.
[82] *Id*. at 4.
[83] *Id*. at 6.
[84] *Id*.

by states that expanded Medicaid than states that did not.[85] Buettgens and Blavin note "Given the large and growing cost of health care – the overall level of health care spending in the United States was $3.6 trillion in 2018, or 17.7% of the economy – it is important to understand how the changes in health insurance programs under the ACA affected income inequality."[86]

Buettgens and Blavin's study (which simulated ACA coverage against a variety of factors) found that income inequality decreased both in states that have expanded Medicaid and in those that have not, although the impact was larger among expansion states. The researchers also found that the ACA reduced income inequality within and between groups defined by race/ethnicity, age, and family educational attainment.[87]

Efforts to repeal and/or replace the ACA have ramped up in the past several years, particularly during the Trump administration. Especially with the *California v. Texas* case, efforts to repeal and replace the ACA have largely shifted to the courts. This has begun widespread discussion and debate about the impacts repealing and/or replacing the ACA. Buettgens and Blavin argue that eliminating the ACA would significantly change the distribution of health insurance coverage and allocation of healthcare spending in the U.S.[88] Based on projections from 2019, more than 20 million people would lose health insurance, primarily through decreases in Medicaid and nongroup coverage, if the ACA were to be repealed.[89] Although eliminating the ACA would decrease federal and state spending, it would also significantly increase uncompensated care costs

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[85] Matthew Buettgens et al., *The Affordable Care Act Reduced Income Inequality in the U.S.*, 40 HEALTH AFFAIRS 121, 121-129 (2021) https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2019.00931.
[86] *Id*. at 121-122.
[87] *Id*. at 127.
[88] *Id*. at 128.
[89] *Id*.

and the medical financial burden for families, particularly those with low and middle incomes, who were the chief beneficiaries of the ACA.[90]

Additionally, eliminating the ACA could also worsen other outcomes, such as access to primary care, prescription drugs, and self-reported health.[91] Prior studies found that through 2015, the ACA substantially increased the share of nonelderly people who reported having a personal physician (3.5%) and easy access to medicine (2.4%) and decreased the share who reported being in fair or poor health (3.4%) and who reported that they could not afford care (5.5%) relative to pre-ACA trends.[92] The researchers postulate that "Without the valuable components of health insurance coverage provided by the ACA, income inequality as measured inclusive of various health coverage benefits would revert to pre-ACA levels."[93]

As a result of the robust discussion around repealing or replacing the ACA, many amendments or alternative legislative frameworks have been proposed. Especially in the political arena, those who lean more conservative have attempted to repeal and replace the ACA. This was especially true during the Trump Administration. In 2017, former President Donald Trump and Republicans in Congress unsuccessfully pursued several efforts to repeal and replace the ACA.

One such amendment, the Graham-Cassidy-Heller-Johnson Amendment, introduced in September 2017 would have repealed ACA mandates and premium and cost-sharing subsidies.[94] It would also establish a new state block grant program, the "Market-Based Health Care Grant Program," appropriated at $1.176 trillion over seven years to fund state-designed health care

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[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] *Id.*
[94] *Compare Proposals to Replace the Affordable Care Act*, KAISER FAM. FOUND. (KFF) Sept. 18, 2017 https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/.

reform programs.[95] Block grant funding would be instead of current federal spending for marketplace premium and cost-sharing subsidies and the Medicaid expansion.[96] Under this amendment, states must elect block grant funding or their residents will be ineligible for any federal financial assistance for health care coverage after a certain date.

The Graham-Cassidy-Heller-Johnson Amendment would have retained some private market rules, but would also permit states to set market rules for coverage under the block grant related to covered benefits and rating based on any factor (including health status), other than gender or genetic information.[97] The ACA imposed new insurance market regulations which included requiring guaranteed issue of all non-group health plans during annual open enrollment and special enrollment periods.[98] The Amendment also encouraged the use of Health Savings Accounts by increasing annual tax-free contribution limit and other such changes.[99] Lastly, the Amendment would add a state option to require work as a condition of Medicaid eligibility for nonelderly adults who are not disabled or pregnant, prohibit federal Medicaid funding for Planned Parenthood clinics for one year, and would provide supplemental funding for community health centers.[100]

Another proposal introduced during the Trump Administration was the Better Care Reconciliation Act, initially proposed in June of 2017. Like the above amendment, this legislation would repeal ACA mandates and cost-sharing subsidies.[101] It would also create new association health plan option for small employers and self-employed individuals (aka "small business health

[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] *Id.*

plans"). The Better Care Reconciliation Act would also retain health insurance marketplaces, annual open enrollment periods, and special enrollment periods.[102] Analogous to the above amendment, this act would add a state option to require work as a condition for eligibility for nonelderly Medicaid adults who are not disabled or pregnant and would prohibit Medicaid funding for Planned Parenthood clinics for one year. However, this amendment would have appropriated $44.7488 billion from 2018-2026 for grants to states to support substance use disorder treatment and recovery support services.[103]

Other federally introduced efforts to repeal and/or replace the ACA include: A Better Way: Our Vision for a Confident America (introduced by House Speaker Paul Ryan), Health Care Freedom Act, Restoring Americans' Healthcare Freedom, and the Obamacare Repeal Reconciliation Act of 2017.[104] With the ACA still intact following the Trump presidency, no substantive effort by Republican lawmakers during the previous administration was successful repealing the ACA. However, there have been several proposed amendments to the ACA itself over the course of the Act's lifetime.

One such proposal has been to eliminate the ACA's tax credits.[105] This would cause substantial increases in premiums as well as large declines in enrollment. By subsidizing coverage, the federal government helps to lower premiums in the ACA-compliant market.[106] Individuals with large medical expenses are likely to sign up for health insurance coverage regardless of whether they obtain a tax credit. However, individuals who are at lower risk may need a tax credit to

[102] *Id*.
[103] *Id*.
[104] *Id.*
[105] Eibner & Saltzman, *supra* note 4.
[106] *Id*.

incentivize them to sign up.[107] An ACA-compliant market without premium tax credits would consist of a relatively small number of high-risk individuals, preventing the majority of potential enrollees from purchasing affordable coverage.[108]

Yet another proposal involves alternative subsidy structures such as vouchers, which could cause premiums to be more sensitive to the age composition of enrollees.[109] The ACA's premium tax credit structure caps individuals' spending as a percentage of income, up to the price of the second-lowest-priced silver plan. This protects enrollees against premium escalation because, once they have met the required income contribution, the cost of additional premium increases in the benchmark plan are fully offset by the tax credit.[110] According to researchers, the premiums are more sensitive to changes in the share of young adult enrollees under alternative subsidy arrangements, including a fixed-dollar voucher and a fixed-percentage contribution.[111]

Another major plan to replace the ACA, and the current American health insurance system, is Medicare for All, popularized by the 2016 Bernie Sanders presidential campaign. One of the biggest general misconceptions about Medicare for All is that it is a single proposal. In fact, there are multiple different proposals to implicate such a reform. The most popular however are those proposed by Senator Bernie Sanders and Rep. Pramila Jayapal in S.1129 and H.R. 1384, respectively.[112] The Sanders/Jayapal bills share many similarities such as: comprehensive benefits, tax-financing, replacement for all private health insurance (including the current Medicare program), lifetime enrollment, no premiums, and all state-licensed, certified providers who meet

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[107] *Id.*
[108] *Id.*
[109] *Id.*
[110] *Id.*
[111] *Id.*
[112] Stephanie Booth, *Medicare for All: What Is It and How Will It Work?* HEALTHLINE (Aug. 26, 2020) https://www.healthline.com/health/what-medicare-for-all-would-look-like-in-america#2.

eligible standards can apply.[113] Other bills include a different spin on single-payer health insurance such as the right to opt out of the plan, or make the plan eligible only to people between the ages of 50 and 64.[114] Other proposals by 2020 presidential candidates included ones more analogous to that of former South Bend, Indiana Mayor Pete Buttigieg who advocated for "Medicare for All who want it," which would add a public option to the ACA.[115]

Medicare for All as proposed by Sanders and Jayapal would move the U.S. from a multi-payer healthcare system into what is known as a single-payer system.[116] Currently, multiple groups pay for healthcare including private health insurance companies, employers, and the government.[117] Single-payer is an umbrella term for multiple approaches. In essence, a single-payer system means your taxes would cover health expenses for the whole population, to a definition from the Journal of General Internal Medicine Trusted Source.[118] The main objective of a single-payer system is to implement a system more similar to that of Canada, the UK, and Australia, where the government is the single entity paying for healthcare.

When comparing the U.S.'s current multi-payer system to that of single-payer systems, the U.S. ranks last "on measures of quality, efficiency, access to care, equity, and the ability to lead long, healthy, and productive lives."[119] This is compared to six other major industrialized countries – Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom. Additionally, the U.S. has the most expensive system compared to these nations.[120] The single-payer system would largely eliminate the role of private health insurance companies and employers

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[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] *Id.*
[120] *Id.*

in providing health insurance and paying for healthcare. Additionally, under a Medicare for All framework, the current Medicare program would be expanded to cover everyone, and would include much more robust benefits (such as long-term care) that are not currently covered by Medicare.[121]

Under the Medicare for All proposals that currently exist, there would be virtually no out-of-pocket costs for healthcare-related expenses and the bills currently proposed would prohibit deductibles, coinsurance, co-pays, and surprise medical bills for healthcare services and items covered under Medicare for All.[122] Similarly to the ACA, pre-existing conditions would also be covered under Medicare for All proposals. This includes cancer, diabetes, asthma, and even high blood pressure. In this sense, Medicare for All would operate similarly to the ACA. Additionally, Medicare for All would allow you to go see any doctor with far fewer restrictions than currently exist under private insurance. While Medicare for All has many potential solutions for the issues that arise in current U.S. health insurance, it remains a divisive topic, and whether in practice this transition will be feasible remains to be seen.

In addition to proposals to repeal, replace, and amend the ACA, the Biden-Harris Administration has implemented its own changes to the ACA, as well as has encouraged increased enrollment in ACA-covered services. "The State of the ACA," a report published by the Centers for Medicare and Medicaid Services (CMS), illustrates that the ACA is at the strongest it has ever been thanks to President Biden's robust investments through the American Rescue Plan (ARP).[123]

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[121] *Id.*
[122] *Id.*
[123] *On 12-Year Anniversary of the Affordable Care Act, New HHS Report Shows Ways the Biden-Harris Administration's American Rescue Plan Investments Are Lowering Health Care Costs and Expanding Coverage*, *Newsroom Press Release*, CMS.GOV (Mar. 23, 2022) https://www.cms.gov/newsroom/press-releases/12-year-anniversary-affordable-care-act-new-hhs-report-shows-ways-biden-harris-administrations.

According to the report, nationwide, 2.8 million more consumers are receiving tax credits in 2022 compared to 2021.[124] These tax credits were an essential component of helping families keep more money in their pockets in the wake of the COVID-19 pandemic.

The Biden-Harris Administration also recently announced a new SEP (special enrollment period) opportunity for low-income consumers with household incomes under 150% of the Federal Poverty Level who are eligible for premium tax credits under the ACA and ARP, which is approximately $19,000 for an individual and $40,000 for a family of four in 2022. In states that use HealthCare.gov (a marketplace platform), 45% of consumers who signed up for health coverage during the 2021 SEP had household incomes under 150% of the Federal Poverty Level. This new SEP will make it easier for low-income people to enroll in Marketplace coverage throughout the year and benefit from the ARP savings.

In November 2021, the House of Representatives passed President Biden's Build Back Better Act (BBBA), which stalled in the Senate. The BBBA would not only significantly improve health care coverage for Americans, but it would also significantly improve Medicaid coverage and provide Medicare hearing care coverage for the first time.[125] Additionally, the BBBA would reduce drug prices and cost sharing and would address social determinants of health such as housing, maternal and childhood nutrition, and childcare.[126] With regards to the ACA, the BBBA would extend three key enhancements to the premium tax credits created by the ARP. These provisions would: ensure that through 2025, no one has to spend more than 8.5% of household income on premiums, increase premium subsidies through 2025 for people with incomes between

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[124] *Id*.
[125] Timothy S. Jost, *How the Build Back Better Bill Would Improve Affordable Care Act Coverage*, COMMONWEALTH FUND (Jan. 19, 2022), https://www.commonwealthfund.org/blog/2022/how-build-back-better-bill-would-improve-affordable-care-act-coverage.
[126] *Id*.

100% and 400% of the FPL, and permit people who receive unemployment compensation to get marketplace subsidies through 2022.[127]

One of the main goals of the BBBA in regards to healthcare spending is that of lowering prescription drug prices.[128] The BBBA would authorize Medicare to negotiate for the price of certain drugs directly with manufacturers, require rebates from drug price increases above the rate of inflation, and cap Medicare Part D out-of-pocket costs at $2,000 per year.[129] The BBBA also limits cost-sharing for insulin and insulin products at $35 for a 30-day supply in Part D plans as well as private insurance. This would mean that diabetics with private coverage would be protected from high out-of-pocket costs for life-sustaining medication.[130] The CBO estimates that that the bill's provisions related to prescription drugs would result in approximately $297 billion in federal savings.[131]

Further, current federal law prevents the government from participating in drug price negotiation, regulating drug prices, or limiting annual drug price increases for Medicare. As a result, drug companies often set prices as high as the market will allow.[132] In 2021, some hiked drug prices up by as much as 10%. The BBBA would allow the secretary of the U.S. Department of Health and Human Services to negotiate drug prices for Medicare drugs with the highest total expenditures, including those administered in physician offices and those taken at home by patients. Drug companies that did not take part in this negotiation would face a steep excise tax,

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[127] *Id*.
[128] Emily Gee et al, *The Build Back Better Act Would Improve Health Care and Lower Costs*, CTR. FOR AM. PROGRESS (CAP) (Dec. 6, 2021) https://www.americanprogress.org/article/the-build-back-better-act-would-improve-health-care-and-lower-costs/.
[129] *Id*.
[130] *Id*.
[131] *Id*.
[132] *Id*.

and companies that did not give access to a drug at the negotiated price would face civil monetary penalties.[133]

Yet another loose end that still needs to be addressed in the context of ACA reform and amendments is the issue of long-term care facilities, nursing homes, and elderly care. However, this issue and those surrounding so-called "Medicaid beds" are beyond the scope of this paper. Health insurance and the healthcare industry are fraught with complex and ever-changing norms about how to best serve the sick, the aging, racial and ethnic minorities, and those with low incomes. With new administrations and social attitudes, the scope of the ACA is bound to change over time. What remains to be seen is what impacts such changes will have on the delivery of medical care and health insurance in the U.S.

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[133] *Id*.