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CONSUMER-DIRECTED HEALTHCARE BY ANY OTHER NAME WOULD BE... OBAMACARE

JEFFREY B. HAMMOND*

I. INTRODUCTION

Obamacare is off to a rough start, all things considered.¹ To be sure, proponents of the Patient Protection and Affordable Care Act of 2010 (ACA) were substantially bolstered in the summer of 2012 when the Supreme Court ruled in *NFIB v. Sebelius* that the “individual mandate” was constitutional.² Of course, with the sweet came the bitter, as the Court also ruled that states did not have to expand their Medicaid programs to cover citizens at or below 138% of the Federal Poverty Level.³ So far, only 26 states have undertaken Medicaid expansion.⁴ Notwithstanding this important victory, supporters of the statute have faced serious challenges in

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1. “Obamacare,” of course, refers to the Patient Protection and Affordable Care Act of 2010, *Where Can I Read the Affordable Care Act?*, HEALTHCARE.GOV, <https://www.healthcare.gov/where-can-i-read-the-affordable-care-act/> (last visited Apr. 17, 2014); The Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010) [hereinafter ACA]. Although the term “Obamacare” can be seen as derisive, I have adopted it in this Article because President Obama himself used the term with approbation. See Dana Davidson, *Obamacare or Affordable Care Act: Wording Matters in Health Care Debate*, CNN.COM (Dec. 4 2013, 8:14 PM), <http://politicalticker.blogs.cnn.com/2013/12/04/obamacare-or-affordable-care-act-wording-matters-in-health-care-debate/>. There, President Obama said the following: “‘I know people call this law Obamacare and that’s OK. Because I do care. I do,’ Obama said Wednesday at a White House Youth Summit, eliciting laughter and applause. ‘I care about you. I care about families. I care about Americans.’” Additionally, this source claimed that the last time the President used the term “Obamacare” was in a speech on November 8, 2013. However, other sources suggest that the President and his staff are trying to move away from the “Obamacare” label. See Peter Grier, *‘Obamacare’ vs. ‘Affordable Care Act’: Does the name matter?*, CHRISTIAN SCI. MON., Nov. 29, 2013, available at <http://www.csmonitor.com/USA/DC-Decoder/Decoder-Buzz/2013/1129/Obamacare-vs.-Affordable-Care-Act-Does-the-name-matter>.

2. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2600, 2601 (2012).

3. *Id.* at 2607, 2608.

4. See KAISER FAMILY FOUND., *WHERE ARE STATES TODAY? MEDICAID AND CHIP ELIGIBILITY LEVELS FOR CHILDREN AND NON-DISABLED ADULTS AS OF JANUARY 1, 2014* (2014), <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicare-and-chip/>.

implementing the ACA's vast array of provisions and new initiatives. The statute is so large that one commentator has claimed that, altogether, it contains the most substantial changes to the American healthcare system since the Medicare Act was signed into law in 1965.⁵

Undoubtedly, though, Obamacare's most pressing problems are fixed on its website — the infamous HealthCare.gov.⁶ The federal website exists because, heretofore, about two-thirds of the states have refused to establish "exchanges" — virtual meeting places where willing sellers of health insurance and buyers from the individual market can meet up for the sale and purchase of health insurance policies.⁷ It would be impossible to catalog all of the problems with the federal website, but even a partial remonstrance demonstrates how fundamental the problems have become with Obamacare's implementation — problems that, as we shall see, call into question the wisdom of the entire project itself.

The main problem with the website is the website itself. Upon its big reveal to the public on October 1, 2013, it was very soon apparent that the site was not "ready for prime time." Customers who desired to sign up for

5. *Understanding the Affordable Care Act*, KAISER PERMANENTE, <http://healthreform.kaiserpermanente.org> (last visited Apr. 10, 2014) ("On March 23, 2010, the Affordable Care Act (ACA) became federal law. It initiated the most significant changes in the U.S. health care system since Medicare was established in 1965."); *Health Law Kickoff May be More Challenging than Medicare's Start*, CAPITAL PUBLIC RADIO, <https://www.caprдио.org/10949> (last visited Apr. 10, 2014) ("Ever since the Affordable Care Act passed, health policy makers have been comparing it to another moment in history. 'Is this the most important step that we've taken towards health care since Medicare?' asked President Obama rhetorically during a recent speech. 'Absolutely.' 'The Affordable Care Act is the biggest change in health care since Medicare,' declared the director of Covered California, Peter Lee. And U.S. Secretary of Health and Human Services Kathleen Sebelius called the Affordable Care Act 'the most powerful law for reducing health disparities since Medicare and Medicaid were created in 1965.'").

6. See HEALTHCARE.GOV, <https://www.healthcare.gov> (last visited Apr. 22, 2014).

7. *Get Covered: A One-page Guide to the Health Insurance Marketplace*, HEALTHCARE.GOV, <https://www.healthcare.gov/get-covered-a-1-page-guide-to-the-health-insurance-marketplace> ("Here's a quick rundown on the most important things to know about the Health Insurance Marketplace, sometimes known as the health insurance 'exchange.'"). For the latest numbers of states that have established state-based exchanges, see KAISER FAMILY FOUND., *State Decisions for Creating Health Insurance Marketplaces, 2014*, available at <http://kff.org/health-reform/state-indicator/health-insurance-exchanges> (last visited Apr. 10, 2014) (claiming that as of May 28, 2013, 17 states had established state-based Marketplaces, seven states had entered into a partnership marketplace in conjunction with the federal government, and 27 states are depending on the federally facilitated marketplace). See HEALTHCARE.GOV, <https://www.healthcare.gov> (last visited Apr. 22, 2014). Some of these states have experienced troubles with their exchanges like the federal government's exchange website. See, e.g., Abby Goodnough & Reed Abelson, *Some State Insurance Exchanges Continue to Battle Technical Problems*, N.Y. TIMES, Nov. 13, 2014, at A18.

insurance faced nearly interminable waits to complete their applications, if they could complete them at all.⁸ Those who braved the phone application work-around were confronted with yet another round of seemingly endless lines that made the phone workaround promised by the Obama administration as ineffective as the website.⁹ This was a problem for one main reason: the statute was written such that customers in the individual market could simply go online to sign up for insurance.¹⁰ President Obama himself said that he wanted shopping for insurance to be as simple as shopping for an item “on Amazon.com.”¹¹ When customers could not start,

8. Wyatt Andrews & Anna Werner, *Healthcare.gov Plagued by Crashes on 1st day*, CBS EVENING NEWS (Oct. 1, 2013, 11:14 PM), available at <http://www.cbsnews.com/news/healthcaregov-plagued-by-crashes-on-1st-day> (chronicling crashes of the federal and some state exchange websites during the first day of open enrollment on October 1, 2013). See also Carol Platt Liebau, “Improved” ObamaCare Site Crashes Live, TOWNHALL.COM (Dec. 1, 2013), <http://townhall.com/tipsheet/carolplattliebau/2013/12/01/improved-obamacare-site-crashes-live-on-cnn-n1755751>. See also David Martosko, *New Obamacare Website ‘Fix’ Crashes Just as White House Boasts of its Success*, LONDON DAILY MAIL (Dec. 2, 2013), <http://www.dailymail.co.uk/news/article-2517077/new-designed-fix-obamacare-website-crashes-white-house-boasts-it.html> (describing how a repair to the federal exchange website crashed as the White House press secretary was discussing it with the media).

9. Devin Dwyer, *Obamacare Paper, Phone, Web Apps, ‘Stuck in the Same Queue,’ Memos Notes*, ABC NEWS (Nov. 2, 2013), <http://abcnews.go.com/blogs/politics/2013/11/obamacare-paper-phone-web-apps-stuck-in-the-same-queue-memos-note> (describing how paper and telephone applications for exchange-based insurance were in the same line for processing as were web-based applications). See also Greg Olson, *Surprise: Obamacare’s 1-800 Number Doesn’t Work Either*, TOWNHALL.COM (Oct. 24, 2013), <http://townhall.com/tip-sheet/guybenenson/2013/10/24/surprise-obamacares-1800-number-doesnt-work-either-n1731097> (describing long waits for the telephone enrollment system coupled to the website).

10. See ACA § 1413 (codified at 42 U.S.C. § 18083(b)(1)(A)(ii) (2010)).

11. See Barrack Obama, President of the United States of America, Remarks by the President on the Affordable Care Act at Prince George’s Community College (Sept. 26, 2013), available at <http://www.whitehouse.gov/the-press-office/2013/09/26/remarks-president-affordable-care-act>. During this speech, President Obama said the following comparing exchange websites (including the federal exchange website) to amazon.com:

Starting on Tuesday, every American can visit HealthCare.gov to find out what’s called the insurance marketplace for your state. Here in Maryland, I actually think it’s called MarylandHealthConnection.gov. (Applause.) MarylandHealthConnection.gov. But if you go to HealthCare.gov, you can look and they’ll tell you where to go. They’ll link to your state. Now, this is real simple. It’s a website where you can compare and purchase affordable health insurance plans, side-by-side, the same way you shop for a plane ticket on Kayak—(laughter)—same way you shop for a TV on Amazon. You just go on and you start looking, and here are all the options. It’s buying insurance on the private market, but because now you’re part of a big group plan—everybody in Maryland is all logging in and taking a look at the prices—you’ve got new choices. Now you’ve got new competition, because insurers want your business. And that means you will have cheaper prices. (Applause.) So you enter in some basic information about yourself, what level of coverage you’re looking for. After that, you’ll

much less complete, a relatively simple application, they became discouraged and dismissed the website as unwieldy and unworkable.¹²

To make matters even worse, after the first wave of website fixes was made, news began to leak that the website had a much more significant, even fundamental problem. The lead contractor admitted that it had not yet built the part of the website that would perform the main “back of the house” functions for the exchange.¹³ These functions are the main conduit between the federal government, as sponsor of the exchange, and the insurance companies that write policies for consumers. There are three main functions that are critically important for the success of the website and Obamacare that are presently in limbo: (1) confirmation of insureds’ enrollment information, (2) crediting the tax subsidy money ultimately to the insurers on behalf of consumers who are qualified for those subsidies, and

be presented with a list of quality, affordable plans that are available in your area. It will say clearly what each plan covers, what each plan costs. The price will be right there. It will be fully transparent. Before this law, only a handful of states required insurance companies to offer you instant price quotes, but because of this law, insurers in all 50 states will have to offer you instant price quotes. And so if you’ve ever tried to buy insurance on your own, I promise you this is a lot easier. It’s like booking a hotel or a plane ticket.

See also Liz Goodwin & Oliver Knox, *Obama Announces ‘Keep Your Plan’ Obamacare Fix*, YAHOO NEWS (Nov. 14, 2013), <http://news.yahoo.com/obama-to-make-obamacare-state-ment-at-11-35-a-m-145708141.html>. “After promising on Oct. 1 that buying insurance on the federal website would work “the same way you’d shop for a plane ticket on Kayak or a TV on Amazon,” a more chastened Obama acknowledged that “buying health insurance is never going to be like buying a song on iTunes.” *Id.*

12. See Scott Gottlieb, *The Conversion Rate on Healthcare.gov: The Obamacare Number No One is Talking About*, FORBES.COM (Jan. 17, 2014), <http://www.forbes.com/sites/scottgottlieb/2014/01/17/the-conversion-rate-on-healthcare-gov-this-obamacare-number-that-no-body-is-talking-about-may-be-the-most-revealing>. In this article, Gottlieb, a writer on health policy and public health asserts the following:

According to government tallies, 44.5 million people called or visited state and federal websites they said, presumably indicating broad interest in the new benefit. But we also know that only 2.2 million people have signed up for Obamacare. Factoring in all of the professed web traffic, this would mean that the number of people who signed up (but didn’t necessarily pay) for an Obamacare health plan amounts to a conversion rate of less than 5% of the Obamacare web traffic. And this is among consumers who had the patience to navigate the faulty Obamacare web portals. This data strongly suggests that eligible consumers, who take the time to kick the tires on Obamacare, don’t like the products that they’re finding in the exchanges. They’re browsing, but not buying.

13. See Sandhya Somashekhar, *Up to 40 percent of Obamacare’s ‘Back Office’ Functions Yet to be Built, Tech Chief Says*, WASH. POST, Nov. 19, 2013, http://www.washingtonpost.com/.../health-science/up-to-40-percent-of-obamacares-back-office-functions-yet-to-be-built-tech-chief-says/2013/11/19/2d884850-5149-11e3-9fe0-fd2ca728e67c_story.html.

(3) crediting money to insurers of high-risk patients.¹⁴ Consumers are therefore left with a buggy virtual storefront that is only two-thirds complete.¹⁵ And, even if they are able to register their information with the website, it is not at all certain that their personal information, much less the subsidies that necessitated the exchange in the first place, would be available. In other words, the incomplete website imperils the entire Obamacare project.

If it were not enough that the internal architecture of the website is both incomplete and riddled with errors, its shoddiness is manifesting itself with serious security vulnerabilities. One computer security expert has said that the exchange website is so insecure that some of its security vulnerabilities do not even require hacking into the website.¹⁶ This expert thinks that applicants' personal information is open to snatching by hackers.¹⁷ This is a powerful disincentive for consumers who otherwise could, or even would, sign up for insurance through the exchanges to follow through and actually do so. Further, when coupled with the other misdirections, mishaps, and mistakes of the website's launch, the security issues could allow the public that is to be served by Obamacare to question its importance and its viability. The security concerns could be the nail in the coffin of Obamacare's credibility. The President and his healthcare team will have a hard time convincing the American public that an advanced technological medium, like the federal website, is the best way to solve the insurance coverage crisis facing America today.

Furthermore, because the federal exchange website has not operated even remotely as planned, the Obama administration and the Department of Health and Human Services have seen fit to delay many of the implementation deadlines found in the ACA. Among those delays are: (1) an eight day delay of the December 2013 deadline to enroll for an exchange plan and be covered by January 1, 2014;¹⁸ (2) on that same day,

14. *Id.*

15. *Id.*

16. See Julianne Pepitone, *Hackers: Healthcare.gov Still Riddled with Potential Security Issues*, NBC NEWS TECHNOLOGY (Jan. 16, 2014), <http://www.nbcnews.com/technology/hackers-healthcare-gov-still-riddled-potential-security-issues-2D11940198>.

17. *Id.*

18. See Tom Howell, Jr., *Administration Stretches Another Obamacare Deadline*, WASH. TIMES, Nov. 22, 2013, <http://www.washingtontimes.com/news/2013/nov/22/republicans-cry-foul-over-2014-obamacare-delay/?page=all> (describing how the Obama Administration moved the deadline from December 15, 2013 to December 23, 2013 for individuals to enroll for an exchange-based plan and have coverage on January 1, 2014). See also Jennifer Haberkorn & Carrie Budoff Brown, *White House Delays Obamacare Deadline*, POLITICO, Dec. 23, 2013, <http://www.politico.com/story/2013/12/obamacares-next-big-test-101464.html>. (describing how, after the Administration had delayed the December enrollment deadline by

the Administration delayed the “open enrollment” period for Obamacare in 2014 to commence after the mid-term congressional elections;¹⁹ (3) earlier, the Administration delayed by six weeks the deadline (date of the deadline) by which individuals must purchase individual plans in order to be covered by the coverage deadline of March 31, 2014;²⁰ (4) the Administration

eight days, it extended its delay by one more day). Even so, the Administration allowed another “special enrollment period” for people who had problems enrolling through the website. See Dan Diamond, *Obamacare Deadline Keeps Getting Delayed, Even as Enrollment Skyrockets*, FORBES.COM (Dec. 25, 2013), <http://www.forbes.com/sites/dandiamond/2013/12/25/obamacare-deadline-keeps-getting-delayed-even-as-enrollment-skyrockets>.

19. See Dan Mangan, *Two More Obamacare Delays: Enrollment Extensions in this Year and Next*, CNBC (Nov. 22, 2013), <http://www.cnbc.com/id/101221874> (describing, *inter alia*, the Administration’s delay of the exchange open enrollment until mid-November 2014, ending in January of 2015).

20. See Bernice Napach, *Obamacare Deadline Delayed; Beware the Insurance “Death Spiral” Says Josh Barro*, YAHOO FINANCE (Oct. 24, 2013), <http://finance.yahoo.com/blogs/daily-ticker/obamacare-deadline-delayed-beware-insurance-death-spiral-says-155612417.html> (describing the Obama Administration’s decision to move the deadline for enrolling in an exchange from February 15, 2014 to March 31, 2014, the last date of open enrollment). The open enrollment deadline was moved to April 15, 2014 for people who had trouble completing their applications on the federal exchange website. See Kate Rogers, *ACA Enrollment Update: 8 Million Americans Have Signed Up*, FOXBUSINESS.COM (Apr. 17, 2014), <http://www.foxbusiness.com/personal-finance/2014/04/17/aca-enrollment-update-8-million-americans-have-signed-up>. Some states also extended the deadline for open enrollment past March 31. See Jason Millman, *Here’s How We Got to 8 Million Obamacare Signups*, WASH. POST, WONKBLOG, (Apr. 17, 2014, 5:18 PM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/04/17/heres-how-we-got-to-8-million-obamacare-signups/>. The federal and state exchanges have been fixed to the point that about eight million Americans registered for health insurance. See Michael F. Cannon, *Obama Brags about Obamacare Rollout as if he Invented the Handout*, FORBES.COM (Apr. 18, 2014, 5:08 PM), <http://www.forbes.com/sites/michaelcannon/2014/04/18/obama-brags-about-obamacare-enrollment-as-if-he-invented-the-handout> (claiming that the eight million sign-ups for insurance in the exchanges have done just that – signed up for insurance coverage by March 31, 2014. There is no indication that all eight million will pay for their insurance coverage) and Julie Eilperin & David Nakamura, *Obama Hails 8 Million Enrollees for Insurance under Federal Health-care Law*, WASH. POST, Apr. 17, 2014, http://www.washingtonpost.com/politics/obama-hails-8-million-enrollees-for-insurance-under-federal-health-care-law/2014/04/17/db1892b2-c670-11e3-bf7a-be01a9b69cf1_story.html (claiming that it is unclear how many of the eight million enrollees with pay for their insurance. Further, the authors assert that the eight million figure includes people whose insurance was cancelled pursuant to requirements in the ACA. The eight million number does not include more than one million who have enrolled straight away with insurance companies). Also, the eight million figure does not include three million people who signed up for Medicaid. See Sam Baker, *Obamacare Sign-Ups Reach 8 Million*, NAT’L J. (Apr. 17, 2014), <http://www.nationaljournal.com/health-care/obamacare-sign-ups-reach-8-million-20140417>. But see Kyle Cheney & Jennifer Haberkorn, *Obama: 8 million enrolled under ACA*, POLITICO (Apr. 17, 2014, 9:13 PM), <http://www.politico.com/story/2014/04/obamacare-enrollment-8-million-105790.html> (claiming that five million people enrolled for insurance directly with insurance companies).

maintained high-risk pools to in turn continue coverage for those who were caught in the middle of the website implementation errors and would have had their coverage expire on December 31, 2013.²¹ While there is some precedential guidance regarding the ability of the Administration to delay these deadlines,²² that has not deterred critics from claiming that the Administration has acted outside the contours of proper executive action.²³

The Administration compounded its rollout problems by having to scramble in light of the President's promise, made well before the rollout of the federal exchange website, that "[i]f you like your health care plan, you'll be able to keep your health care plan."²⁴ As it turned out, a participant in Obamacare could not necessarily keep the plan she had before the October 1, 2013 rollout of the exchanges. This is because many existing individual plans were canceled or rescinded as they did not meet requirements posed by the ACA.²⁵ These plan rescissions and cancellations proved to be very troubling to exchange consumers for one very important reason: they were counting on the President's promise to be fulfilled. They did not want to go through the trouble of enrolling in a new plan when they

21. See Kate Pickert, *More Obamacare Deadlines Extended*, TIME.COM (Dec. 23, 2013), <http://swampland.time.com/2013/12/12/more-obamacare-deadlines-delayed/> (describing how the Administration was sustaining "high risk" insurance pools until January 31, 2014 to aid those caught unable to enroll in an exchange plan). That deadline was extended until March 15, 2014. See Jonathan Easley, *WH Delays Another Obamacare Deadline*, THE HILL (Jan. 14, 2014), <http://thehill.com/blogs/healthwatch/health-reform-implementation/195468-wh-delays-another-obamacare-deadline>.

22. See Sarah Kliff, *The White House Keeps Changing Obamacare. Is that Legal?*, WASH. POST, WONKBLOG (Aug. 7, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/08/07/the-white-house-keeps-changing-obamacare-is-that-legal/> (describing the administrative law involved in executive implementation of statutes passed by Congress).

23. *Id.* (recounting that a criticism of the Administration's delays is that the Executive has not maintained faithful execution of the laws, as required by the Constitution).

24. See Obama: 'If You Like Your Health Care Plan, You'll be Able to Keep Your Health Care Plan', TAMPA BAY TIMES, <http://www.politifact.com/obama-like-health-care-keep> (cataloging 37 instances of where President Obama asserted that citizens would be able to keep either their health plans or their doctors after the changes wrought by the ACA) (last visited Apr. 14, 2014),

25. See D'Angelo Gore, *Fact Check: If You Like Your Health Plan, You Can Keep It*, USA TODAY (Nov. 11, 2013), <http://www.usatoday.com/story/news/politics/2013/11/11/fact-check-keeping-your-health-plan/3500187/> (detailing the rules on "grandfathered" plans, including, *inter alia*, that such plans must have been in existence since March 23, 2010, the date the ACA was signed into law by President Obama, and that they must "not be changed to cut benefits or significantly raise prices for consumers through deductibles or co-pays"). See also Clara Ritger, *Obama Administration to Delay Individual Mandate for Some*, NAT. J. (Dec. 19, 2013), <http://www.nationaljournal.com/health-care/obama-administration-to-delay-individual-mandate-for-some-20131219> (reporting that the Obama Administration has set aside the individual mandate for one year for those whose plans were cancelled pursuant to the ACA rollout).

were already satisfied with their old plans. Second, the new exchange plans were, in many cases, more expensive, either in premiums or cost-sharing (namely deductibles) than the plans to which they were accustomed.²⁶

The Administration heard the plaintive cries of consumers who expected the President's promise to be honored. Therefore, on November 14, 2013, the Administration reversed course, and in an action initiated by the White House (and which did not go through the normal administrative notice and comment period), told state insurance commissioners that insurers in their respective states were "allowed" to continue to offer plans that were canceled pursuant to the ACA.²⁷ But insurers have spent time, money, and human resources in crafting and vetting plans that comply with the mandates of the ACA.²⁸ For an insurer to re-offer a plan that it had canceled before is, for all intents and purposes, a null set. To re-offer an old plan means in reality to issue it all anew. Further, and more importantly, the insurers had a fairly solid idea of who would be in their ACA-compliant plans' risk pools. According to one health insurance trade group, "premiums have already been set for next year based on an assumption when consumers will be transitioning to the new marketplace."²⁹

The significant problems with the federal exchange website represent issues with *process*, or the way that the Obamacare standards and program for individual insurance has been presented and marketed to the public. These problems do not, by themselves, represent problems with the *product* of Obamacare individual insurance. Unfortunately for the Obama administration, there too are vexing problems with the substance of individual plans offered through the federal exchange that prevent the rollout of Obamacare from being even a moderate success.

For example, before the passage of the ACA, one of the hallmarks of the individual insurance market was that consumers had a wide array of choices when designing an insurance plan. Now, however, the ACA mandates that all plans sold on the federal and state exchanges offer the ten

26. See Peter Frost, *Obamacare Deductibles a Dose of Sticker Shock*, CHI. TRIB., Oct. 13, 2013, http://articles.chicagotribune.com/2013-10-13/business/ct-biz-1013-obamacare-deductibles-20131013_1_health-care-overhaul-health-insurance-health-coverage.

27. See Barack Obama, Statement by the President on the Affordable Care Act (Nov. 14, 2013), available at <http://www.whitehouse.gov/the-press-office/2013/11/14/statement-president-affordable-care-act>.

28. See, e.g., *Affordable Care Act (ACA)*, AETNA, <http://www.aetna.com/individuals-families/member-rights-resources/claims-coverage/affordable-care-act.html> (last visited Apr. 3, 2014).

29. See Press Release, America's Health Insurance Plans, AHIP Statement on Consumers Keeping Their Current Coverage (Nov. 14, 2013), available at <http://www.ahip.org/News/Press-Room/2013/AHIP-Statement-on-Consumers-Keeping-Their-Current-Coverage.aspx> (quoting a statement by America's Health Insurance Plans' President and CEO Karen Ignagni).

main “essential health benefits” as outlined in the statute.³⁰ While the mandated benefits includes vital services like inpatient hospital services, as well as ambulatory (outpatient) services, it also includes things like pre-natal, delivery, and maternal care — services that are certainly vital to some, but not all beneficiaries.³¹ While no health economist can conclude with certainty that Congress’s bootstrapping approach (in requiring the same set of benefits for everyone) has contributed to individual premiums that are higher across the board, anecdotes since the rollout suggest that the inability to fully streamline a palette of benefits has raised overall costs for some consumers.³² A “one size fits all” approach to health plan design suggests that all consumers of every age, risk-profile, and life-situation need the same things from their healthcare coverage. Of course, that simply is not the case. An “empty nest” couple in their late-50s does not need the same set of benefits as the early-30s couple who are not finished having children. Simply, the move toward homogeneity in the individual insurance market serves as an upward governor on consumer prices for significant parts of the consumer population.

Unsurprisingly, the mandates within the ACA have increased premiums for many Americans who have (and will) purchase insurance through the exchanges.³³ It is true that under some methods of macro calculation, premiums have decreased on an overall basis.³⁴ However, even Obamacare apologists who tout certain calculations of overall premiums decreasing acknowledge that there is a great mismatch between consumers in the exchanges.³⁵ Some consumers have experienced significantly high

30. See ACA § 1302(b)(1).

31. *Id.*

32. See, e.g., Carrie Teegardin, *Canceled or Not, Prices Rise for Many*, ATLANTA J. CONST., Oct. 31, 2013, at A1 (recounting an anecdote of a consumer whose overall insurance costs will increase as a result of having to switch to an ACA compliant plan that includes unnecessary medical services).

33. See, e.g., *ObamaCare Insurance Premiums*, OBAMACAREFACTS.COM, <http://obamacarefacts.com/obamacare-health-insurance-premiums.php> (in which a site supportive of the Affordable Care Act writes: “ObamaCare insurance premium increases are a response to the protections contained within the law, such as the mandate for insurers to cover people with pre-existing conditions. Other parts of the law like the rate review provision and the creation of the health insurance marketplace help to reduce premium costs.”) (last visited Apr. 18, 2014).

34. See Ezra Klein, *The Health-Care Trilemma: How Obamacare is Changing Insurance Premiums*, WASH. POST, WONKBLOG (Oct. 29, 2013, 2:28 PM), www.washingtonpost.com/blogs/wonkblog/wp/2013/10/29/the-health-care-trilemma-how-obamacare-is-changing-in-surance-premiums (arguing that the average overall premium in the exchanges projected at 16% less than originally expected).

35. *Id.*

premiums while others have relatively low premiums.³⁶ Unfortunately, this is not a universal phenomenon.³⁷ A significant amount of the premium increases are borne by the young people who are needed to subsidize the older, sicker people who have signed up for insurance in the exchanges.³⁸ The question remains whether these young people (and those who are somewhat older) will, in fact, sign up for exchange-based insurance in numbers big enough to make the exchanges viable. If these numbers do not materialize, insurers could trip into the infamous “death spiral,” which would imperil the whole prospect of private health insurance.³⁹

A potentially more vexing issue with Obamacare is that of deductibles. Like the premiums that consumers in the federal and state exchanges must pay, there is no rhyme or reason to the deductibles charged by insurers for Marketplace-based policies.⁴⁰ For some consumers, their new deductibles have been multiples of what they had to pay in their previous plans.⁴¹ That there has been inexplicable instability with deductibles is more troubling than sharp increases in premiums. For, at least with premiums, the purchaser can coolly assess her budget to determine whether she wants to

36. *Id.* See also Ariana Eunjung Cha & Lena H. Sun, *For Consumers Whose Health Premiums will Go up under New Law, Sticker Shock Leads to Anger*, WASH. POST, Nov. 3, 2013, http://www.washingtonpost.com/national/health-science/for-consumers-whose-health-premiums-will-go-up-under-new-law-sticker-shock-leads-to-anger/2013/11/03/d858dd28-44a9-11e3-b6f8-3782ff6cb769_story.html.

37. See Avik Roy, *49-State Analysis: Obamacare to Increase Individual-Market Premiums by Average of 41%*, FORBES.COM, THE APOTHECARY (Nov. 4 2013, 5:00 AM), www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly (summarizing a Manhattan Institute study that projected premiums for individual policies would increase by 41%).

38. See Matthew Herper, *ObamaCare Raises Health Insurance Premiums, Especially for the Young*, FORBES.COM, (Dec. 5, 2013), www.forbes.com/sites/matthewherper/2013/12/05/obamacare-raises-health-insurance-costs-especially-for-the-young.

39. See Neil Munro, *Obamacare Death Spiral is Underway, Says Study*, DAILY CALLER (Jan. 13, 2014, 3:00PM), <http://dailycaller.com/2014/01/13/obamacare-death-spiral-is-underway-says-study>. But see Ezra Klein, *The Death of Obamacare's Death Spiral*, WASH. POST, WONKBLOG, (Jan. 14, 2014, 12:08 PM), www.washingtonpost.com/blogs/wonkblog/wp/2014/01/14/the-death-of-obamacares-death-spiral (arguing, *inter alia*, that there is no single one risk pool to which young person enrollment contributes; rather each state has its own risk pool, thereby diminishing the effect of December 2013 enrollment numbers (including young person enrollment)).

40. See Aimee Picchi, *For Some Obamacare Deductibles Deliver Sticker Shock*, CBS NEWS, (Dec. 9, 2013, 11:47 AM), www.cbsnews.com/news/obamacare-deductibles-deliver-hefty-sticker-shock.

41. See Peter Frost, *Obamacare Deductibles a Dose of Sticker Shock*, CHI. TRIB. (Oct. 13, 2013), http://articles.chicagotribune.com/2013-10-13/business/ct-biz-1013-obamacare-deductibles-20131013_1_health-care-overhaul-health-insurance-health-coverage (recounting anecdote of an Illinois man whose deductible tripled under an ACA exchange plan).

make the monthly debit from her bank account for the continuing insurance. A deductible, by definition, is the money that an insured must spend before her insurance benefits start.⁴² Since, in many cases, an insured does not know when her insured loss will happen, exactly when she will incur such a large loss is unpredictable. This is doubly risky because those who are covered in the federal and state exchanges might not have the most comfortable cushions of cash reserves that could serve as their deductibles.

Deductibles have been a part of health insurance for as long as there has been health insurance. Heretofore, insureds have been able to contract for the deductibles that have fit the vagaries of their respective needs and budgets. Many workers who were fortunate enough to have health insurance provided by their employers had choices of coverages, premiums, and deductibles. Individuals who, before the ACA found themselves in the market for health insurance, generally had similar choices of the parameters of their insurance coverages. It is also true that individuals shopping for insurance in state and federal exchanges have choices regarding their deductibles. However, what is remarkable about deductibles in some exchange policies is that they bear no reasonable relationship to the coverages or premiums.⁴³

The remainder of this Article will focus on deductibles in the context of the ACA individual insurance markets. In particular, the remainder of the Article asserts that the high deductibles found in exchange-based plans are the new, below-ground way of doing “consumer-directed health care” (CDHC). CDHC is the innovation crafted in the Medicare Modernization Act of 2003 (MMA) in which a Health Savings Account (HSA) or Health Reimbursement Account (HRA) is coupled with a high-deductible health plan (HDHP).⁴⁴ The point of CDHC is for consumers to control their own cost-sharing based healthcare spending.⁴⁵ This Article will assert that, while choice is a key element for CDHC, in that consumers have a choice of whether or not to enroll in a CDHC-based plan, choice is a much diminished element in the Obamacare insurance market. Consumers in the individual market have to purchase insurance and may have to enroll in plans with high deductibles when they do not want those high deductibles.

42. See *Deductible*, HEALTHCARE.GOV, www.healthcare.gov/glossary/deductible (last visited Apr. 18, 2014).

43. For example, one plan has a \$343/month premium with a \$3,750 deductible and 70% coinsurance, while another plan has a \$251/month premium with a \$4,000 deductible and 80% coinsurance. *Id.* Quotes obtained from <http://www.healthcare.gov> for a 45-year-old residing in St. Louis City, MO. See *id.* (last accessed Feb. 16, 2014).

44. Anne K. Gauthier & Carolyn M. Clancy, *Consumer-Driven Health Care – Beyond Rhetoric with Research and Experience*, 39 HEALTH SERV. RESEARCH 1049, 1049 (2006).

45. James C. Robinson & Paul B. Ginsburg, *Consumer-Driven Health Care: Promise and Performance*, 28 HEALTH AFF. w272, w274 (2009).

Part II of the Article will give a brief précis of CDHC as it stands now. Part III will go into greater depth of how high deductibles have affected Obamacare. Part IV will provide a brief conclusion.

II. CONSUMER-DIRECTED HEALTHCARE AS A CREATURE OF INTENTIONALITY

CDHC is a relatively new phenomenon. The MMA, passed by the Congress and signed by President Bush in 2003, allowed for the first time HSAs that could be coupled with a HDHP.⁴⁶ The HSA would allow consumers to save money, on a tax-preferred basis, much like saving in an Individual Retirement Account or 401(k) or 403(b) plan for the purpose of paying medical expenses.⁴⁷ The high-deductible health plan functions exactly like its moniker sounds. A person's (or family's) insurance coverage would only kick in after the deductible was met.⁴⁸ And in many cases, the deductibles on the HDHPs were quite high - oftentimes more than \$3000.⁴⁹ Holders of HDHPs were not left out in the cold, though. They had money that they deposited on an annual basis in their HSAs. This money grew on a tax-free basis. The saved money could be used to pay deductibles, premiums, co-payments, or other expenses not covered by the HDHP.⁵⁰

The key feature of CDHC is that of intentionality.⁵¹ This means that insureds who chose CDHC plans did so because they planned their affairs in such a way as to be able to save for the cost-sharing involved in a CDHC approach to healthcare coverage. CDHC insureds have chosen to save money in their HSAs to cover deductibles and co-payments, should they need to activate coverage in their HDHPs. These insureds have been actively involved in the decision-making about their own healthcare coverage.⁵² They have chosen to direct their money toward savings for possible medical contingencies rather than pay more in monthly premiums in exchange for

46. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003) [hereinafter MMA]. For the main HSA provisions, see MMA § 1201.

47. MMA § 1201 (codified as amended in 26 U.S.C. §§ 223(a), (b), (d)(1)) (describing deduction from taxable income rules and how the HSA functions).

48. 26 U.S.C. 223(c)(1)-(2) (2013).

49. See John Waggoner, *Is a High-Deductible Health Plan for You?*, USA TODAY (Sept. 24, 2013, 2:06 AM), <http://www.usatoday.com/story/money/personalfinance/2013/09/24/high-deductible-health-care-plans/2848181> (claiming that for many HDHPs, "your insurance doesn't kick in until you've met your deductible - often \$3,000 or more").

50. See *id.* (describing how HSAs work).

51. See John C. Goodman, *What Is Consumer-Directed Health Care?*, 25 HEALTH AFF. w540 (2006).

52. See *id.* But cf. M. Gregg Bloche, *Consumer-Directed Health Care*, 355 NEW ENG. J. MED. 1756, 1756 (2006) (claiming that doctors have acted as agents for their patients and made decisions for them).

the security of lower deductibles if the healthcare contingency should happen, and they or a family member should need hospitalization or other expensive medical testing or treatment.

The high-deductible part of CDHC has served as a rationing device for consumers who have purchased these plans. And that should come as no surprise. If one has a \$3,000 or \$5,000 or \$10,000 deductible, one is going to think very hard about whether the ailment, malady, or injury for which one is considering expensive medical treatment, really is worth the cost.⁵³ One balances the relatively low monthly premium one has to pay against the significant chance that the cost of the modality or treatment ordered by the treating physician will not exhaust the deductible amount, thereby placing the insured in the unenviable spot of having to purchase the treatment entirely out of pocket or with precious saved dollars in the insured's HSA.⁵⁴

That CDHC serves as a rationing mechanism is a salutary effect. CDHC plans do appear to downwardly affect overall healthcare costs.⁵⁵ Further, there is emerging evidence that CDHC would continue to lower costs if implemented in a more widespread manner.⁵⁶

The incentives deep within CDHC work for certain subsets of the healthcare consuming public. They work very well for upper-middle class to upper class insureds who have the financial wherewithal to save significant sums for cost-sharing obligations.⁵⁷ They work equally as well for relatively healthy people who are not chronically ill or who do not anticipate consuming significant amounts of healthcare resources.⁵⁸ Contrarily, CDHC does not work very well (from the consumer's perspective) for a person who is consistently under the care of a physician for one or more chronic diseases or who anticipates using costly medical resources that otherwise

53. *But see* Goodman, *supra* note 51, at w541 (Goodman actually criticizes commentators who solely equate CDHC with HDHPs.).

54. *See id.*

55. *See* Melinda Beeuwkes Buntin, *Consumer-Directed Health Care: Evidence About Effects on Cost and Quality*, 25 HEALTH AFF. w516, w523 (2006), available at <http://content.healthaffairs.org/content/25/6/w516.full.html>.

56. *See id.*

57. *See* Steffie Woolhandler & David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, J. GEN. INT. MED. 879, 880-81 (2007). *See also* M. Gregg Bloche, *Consumer-Directed Health Care and the Disadvantaged*, 26 HEALTH AFF. 1315, 1316 (2007) (in which the author, a noted health law and policy expert, fears that CDHC will "probably widen socioeconomic disparities in care and redistribute wealth in 'reverse Robin Hood' fashion from the working poor and middle classes to the well-off").

58. *See* Woolhandler & Himmelstein, *supra* note 57, at 879.

would be at least partially reimbursable by insurance.⁵⁹ In sum, if one is not well, or cannot or will not save, CDHC can pose a significant burden on the consumer. Further, if one gains security from the reliability of readily available health insurance with manageable barriers of entry (in the form of cost-sharing obligations), then CDHC would not be very attractive.

At bottom, CDHC functions as something much more profound than a savings vehicle for the healthy and wealthy. CDHC serves as a half-measure that is a wedge into a "two tiered" healthcare system. It is instructive that CDHC started in earnest with the 2003 adoption of the MMA.⁶⁰ The early to mid-2000s were about the time that concierge medicine and other innovations in ambulatory primary care came into the fore.⁶¹ While concierge or retainer care focuses more on the patient's convenience with a physician who has "opted out" of the traditional insurance-based reimbursement system,⁶² CDHC keeps physicians in the normal delivery system, with doctors accepting HDHPs alongside other health plans.⁶³ Therefore, with CDHC it is the consumer only, and not the consumer with her physician, who has opted out of the vast majority of traditional, fee-for-service healthcare.

If, in fact, CDHC has driven a wedge in helping create a two-tiered ambulatory delivery system, such an outcome is not necessarily negative, and can be an outstanding positive for the system as a whole. Uniformity has never been a requirement of the healthcare delivery or payment system. That there are pockets of consumers committed to CDHC bespeaks not a wholesale rejection of traditional models of cost-sharing, but rather that the law has created space for insureds to make informed decisions about the amount and intensity of their healthcare. What matters is that consumers are making rational choices about their own economical and physical well-beings. Further, they are doing so in a manner that is likely net-neutral to the supply of healthcare providers in the system. For the allure of other forms of two-tiered delivery outlets, like retainer/concierge medicine, that allure is diminished by the likelihood that providers who divert into retainer

59. See, e.g., Colleen L. Barry et al., *Who Chooses a Consumer-Directed Health Plan*, 27 HEALTH AFF. 1671, 1675-76 (reporting, for the firm Alcoa, Inc., lower enrollment in consumer directed health plans by certain segments of the chronically ill population than in PPO plans).

60. See *id.* at 1671.

61. See, e.g., Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15 HEALTH LAW 1, 1 (2003); G. Caleb Alexander et al., *Physicians in Retainer ("Concierge") Practice: A National Survey of Physician, Patient, and Practice Characteristics*, 20 J. GEN. INT. MED. 1079, 1079 (2005).

62. See Portman, *supra* note 61, at 1-3.

63. See *id.* at 3.

practices remove themselves from treating the traditional, insurance-reimbursed patient population.⁶⁴

The question of how CDHC should work is, of course, qualitatively different from the question of how it actually has worked. In the ten-plus years since the passage of the MMA, America has seen robust demand for CDHC.⁶⁵ If anything, the creation of CDHC plans has shown what is possible in the realm of healthcare coverage. The project can be called a success by those who desire more choices and control over their healthcare spending. Its increasing popularity belies judgments of reticence or circumspection by CDHC critics, who desire more modest cost-sharing for patients and other controls on patients' autonomy.⁶⁶ It has functioned well as an alternative to the traditional insurance paradigm.

III. HIGH DEDUCTIBLES IN THE EXCHANGES

High deductibles are antithetical to the public's expectations of ACA exchange plans.⁶⁷ California anticipated deductibles of \$2000 for a "silver"

64. See, e.g., Jack M. Colwill et al., *Will Generalist Physician Supply Meet Demands of an Increasing and Aging Population*, 27 HEALTH AFF. w232, w239 (2008), available at <http://content.healthaffairs.org/content/27/3/w232.full.html>.

65. See John Goodman, *Consumer Health Plans Growing, Have Lower Costs*, JOHN GOODMAN'S HEALTHY POLICY BLOG, NATIONAL CENTER FOR POLICY ANALYSIS (Mar. 6, 2009), <http://healthblog.ncpa.org/consumer-health-plans-growing-have-lower-costs> (describing a survey that claimed that "more than half of companies now offer consumer directed health plans (CDHPs)"). See also John Goodman, *Consumer-Directed Health Plans Soar*, JOHN GOODMAN'S HEALTHY POLICY BLOG, NATIONAL CENTER FOR POLICY ANALYSIS (Apr. 20, 2010), <http://healthblog.ncpa.org/consumer-directed-health-plans-soar> (quoting a survey by Mercer that claimed, *inter alia*, that "60% percentage of large employers that expect to offer CDHPs five years from now").

66. See Bloche, *supra* note 52, at 1757-58 (criticizing high cost sharing for certain poorer and sicker populations). See also Linda M. Axtell-Thompson, *Consumer Directed Health Care: Ethical Limits to Choice and Responsibility*, 30 J. MED. & PHIL. 207, 208, 221 (2005) (criticizing CDHC for an inordinate focus on the bioethical principle of autonomy).

67. But see Alex Nussbaum, *Obamacare Deductibles 26% Higher Make Cheap Rates a Risk*, BLOOMBERG PERSONAL FINANCE (Nov. 15, 2013), <http://www.bloomberg.com/news/2013-11-15/obamacare-deductibles-26-higher-make-cheap-rates-a-risk.html>. In this article, the author quotes health law and policy expert, Timothy Jost:

Prior to Obamacare, \$10,000 to \$20,000 deductibles were common in the individual market, said Timothy Jost, a law professor at Washington and Lee University in Lexington, Virginia, who supports the act. Republicans now criticizing the law have long argued the health-care system would benefit from consumers having "more skin in the game," he said.

"This is essentially Republican health policy, where you have higher cost sharing," Jost said in an interview. "Now that it's individuals who have actual bills they have to pay, it's a problem."

plan,⁶⁸ while a “bronze” plan was anticipated to have a \$5000 deductible.⁶⁹ A person could purchase a “platinum” plan in California, which would entitle the purchaser to be free of any cost-sharing. However, that purchaser’s monthly premium would be substantially higher than the bronze or silver purchaser’s.⁷⁰

In Minnesota, consumers found themselves on the receiving end of high premiums and high deductibles. One family plan costs over \$1,000 per month and has a \$6,000 deductible.⁷¹ Another family-based plan costs over \$877 per month and has a deductible of a whopping \$12,700.⁷² Illinois has significant cost-sharing obligations as well. One newspaper analyzed the exchange plans for Cook County (Chicagoland) Illinois. It found that over ninety-five percent of the lowest priced (premium) plans had deductibles in the range of \$4,000 for individuals and \$8,000 for families.⁷³

See also Leslie Scism & Timothy W. Martin, *Deductibles Fuel New Worries of Health-Law Sticker Shock*, WALL ST. J., Dec. 8, 2013, <http://online.wsj.com/news/articles/SB10001424052702303330204579246211560398876>. In this article, the authors state:

And deductibles had been growing for years. It is unclear how much deductibles would have risen for individually purchased policies if the health law didn’t exist. But deductibles for employer-sponsored plans, which generally are much lower than for individually purchased policies, nearly doubled over the past seven years to \$1,135 in 2013, according to a Deloitte study published this year.

68. See Tami Luhby, *Obamacare: Is a \$2000 deductible ‘affordable?’*, CNN MONEY (Jun. 13, 2013), <http://money.cnn.com/2013/06/13/news/economy/obamacare-affordable>. The story quotes Marian Mulkey, affiliated with the California Healthcare Foundation as saying, “[t]he hardest question is whether it will be a good deal and will consumers be able to afford it The jury is still out. It depends on their circumstances.” *Id.*

69. *Id.*

70. *Id.*

71. See Tami Luhby, *How ‘Affordable’ are Obamacare Plans?*, CNN MONEY (Nov. 21, 2013), <http://money.cnn.com/2013/11/21/news/economy/obamacare-affordable>.

Furthermore, this story embellishes upon the author’s earlier article for CNN Money. Consider her take on California’s exchange a mere five-plus months after her first story about California exchange plans and the cost-sharing requirements under them:

Take a 40-year-old San Francisco resident who rarely sees the doctor. The cheapest plan on the Covered California exchange would cost him more than \$2,800 a year, without federal subsidies. But if he had to go to the doctor more often, he’d have to satisfy a \$5,000 deductible and then pay \$60 for each primary care visit and \$70 for a specialist. He’d have to pay 30% of the cost of lab tests and \$19 for generic drugs or \$50 for preferred brand name prescriptions. The exchange estimates he’ll pay \$500 in out-of-pocket costs annually.

72. *Id.* Importantly, Luhby notes that the ACA caps out-of-pocket expenses, including deductibles, at \$6,350 for individuals and \$12,700 for families. *Id.*

73. See Frost, *supra* note 41 (noting that “21 of the 22 lowest-priced plans offered on the Illinois health insurance exchange for Cook County have annual deductibles of more than \$4,000 for an individual and \$8,000 for family coverage”).

Connecticut anticipated that the cheapest bronze plan would have a \$3,250 deductible for an individual (with several services not included in the deductible) and a \$6,500 deductible for a family plan.⁷⁴ A silver plan has a \$3,000 deductible for medical services and \$400 deductible for prescription drugs and a \$6,000 deductible for medical services and \$800 for prescription drugs.⁷⁵ Gold plans in Connecticut were anticipated to have \$1,000 individual medical deductibles with a \$150 deductible for prescription drugs, with a \$2,000 medical deductible for family plans with a \$300 prescription drug deductible.⁷⁶ One of New Jersey's insurer's cheapest plan for older citizens not yet eligible for Medicare has a \$5,000 deductible.⁷⁷

Those are just a sample of exchange-based deductibles in states that have their own exchanges. Deductibles from the federal exchange are similarly high. The *Wall Street Journal* reports that the median deductible for an individual bronze plan sold on the federal exchange is a little over \$5,000.⁷⁸ The health insurance website, HealthPocket, claims that the average bronze family deductible is \$10,386.⁷⁹ Further, HealthPocket has determined that the average silver individual deductible is \$2,907 with a family deductible of \$6,078.⁸⁰ It determined that the average gold individual deductible at \$1,277 and family deductible of \$2,846.⁸¹ It also determined that the average platinum deductible at \$347 and family deductible at \$698.⁸²

All of these anecdotes and their supporting data give rise to the question: why would anyone buy an individual insurance plan with a high deductible from an ACA exchange? Two answers are obvious at this point.

74. Arielle Levin Becker, *The Obamacare Premiums Are In. But What about Deductibles and Copays?*, CT MIRROR (Aug. 7, 2013), <http://ctmirror.org/obamacare-premiums-are-what-about-deductibles-and-copays>.

75. *Id.*

76. *Id.*

77. Robert Sciarrino, *Obamacare: How Affordable is Health Insurance after the Affordable Care Act?*, NJ.COM (Oct. 20, 2013, 9:40 AM), http://www.nj.com/news/index.ssf/2013/10/obamacare_how_affordable_is_health_insurance_after_the_affordable_care_act.html (noting the average deductible for a couple of 55-year olds).

78. See Scism & Martin, *supra* note 67 (reporting that: "the average individual deductible for what is called a bronze plan on the exchange - the lowest priced coverage - is \$5,081 a year, according to a new report on insurance offerings in 34 of the 36 states that rely on the federally run online marketplace").

79. See Kev Coleman, *Deductibles, Out-Of-Pocket Costs, and the Affordable Care Act*, HEALTHPOCKET (Dec. 12, 2013), http://www.healthpocket.com/healthcare-research/infostat/2014-obamacare-deductible-out-of-pocket-costs#.Uv_EckJdWTW.

80. *Id.*

81. *Id.*

82. *Id.*

One, individuals and families buy health insurance, even insurance with high deductibles, because they want shelter from the storm of unforeseen and costly medical goods and services. Medical care without insurance is expensive — prohibitively so for all but the most wealthy Americans.⁸³ Second, the ACA requires it.⁸⁴ However, high deductibles have some individuals and families wondering if having health insurance is worth it. If a family is going to have to spend \$5,000 or more, just for the privilege of having to spend more money on co-insurance payments (alongside their insurance benefits, to be sure); such an option does not sound like a very attractive option for many middle-class Americans.⁸⁵

This seems to be an opinion shared by others. Bronze plans have been called “smoke-and-mirrors catastrophic plans” by one health insurance broker, whose benefits only kick in when something truly awful happens to a person (or member of his family) — something that would be expected to incur significant medical costs.⁸⁶ Another person who enrolled in an exchange-based plan said of the deductibles, “the deductibles were so high — \$4,000 to \$6,000 a year — that it defeats the purpose of having insurance.”⁸⁷ Further, a health insurance consultant said the following about high deductibles:

A lot of people aren't ever going to get out of that deductible . . . Only if you have a catastrophic health event or you're really chronically ill will you ever hit your out-of-pocket cap. People are left, I think, feeling like 'I spent a lot of money this year on premium and I didn't get any meaningful coverage from my insurance.'⁸⁸

83. See Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013, at 16-55 (describing exorbitant full charge prices by hospitals and other health care facilities to people without insurance or whose insurance benefits have run out).

84. ACA § 1501.

85. But see, Michelle Andrews, *In Addition to Premium Credits, Health Law Offers Some Consumers Help Paying Deductibles and Co-Pays*, KAISER HEALTH NEWS, (Jul. 9, 2013), <http://www.kaiserhealthnews.org/features/insuring-your-health/2013/070913-michelle-andrews-on-cost-sharing-subsidies.aspx> (discussing premium subsidies for exchange consumers who have incomes within 400% of the federal poverty level and cost-sharing subsidies for persons whose incomes are within 250% of the federal poverty level).

86. See Frost, *supra* note 41 (quoting Rich Fahn, an Illinois insurance broker, before continuing the story and explaining that bronze plans “don’t provide benefits until and unless something bad happens — a car wreck, a major surgery or a chronic illness”).

87. Robert Pear, *On Health Exchanges, Premiums May be Low, but Other Costs Can be High*, N.Y. TIMES, Dec. 9, 2013, at A18 (quoting Mark A. York of Idaho and also providing several other examples of high deductibles in exchange plans).

88. See Carrie Feibel, *One Texan Weighs Obamacare Options: High Deductible Vs. ‘Huge Fear’*, KAISER HEALTH NEWS (Dec. 26, 2013), <http://www.kaiserhealthnews.org/stories/2013/december/23/high-deductible-insurance-costs-consumers.aspx> (quoting Caroline Pearson, a health insurance consultant).

The payment of a relatively expensive deductible in exchange for little or no “payoff” in the form of insurance benefits surely is distressing for consumers who expected, when shopping for exchange based plans, to find coverage that fit within their budgets, much less their expectations. It is also understandable that some consumers would question the entire prospect of the ACA — that of normalizing access to health insurance to everyone in the United States — if procuring that insurance has no practical benefit for a large cohort of those consumers.

The high deductibles of (primarily) bronze and silver plans in the exchanges represent a form of CDHC through the back door, if deductibles were the whole of CDHC.⁸⁹ However, as asserted earlier in this Article, one of the hallmarks of CDHC is intentionality by the consumer. That is, the consumer coolly assesses her budget and her (anticipated) healthcare needs and then makes the rational decision to purchase a high deductible health plan and contribute to a HSA. Unfortunately, this type of detached deliberation and economizing does not appear to apply among many exchange customers. Indeed, many, if not most, exchange consumers appear to desire “regular” insurance — insurance that is not premised on a

89. See Don McCanne, *Obamacare is the Trojan Horse for What!?*, PHYSICIANS FOR A NAT’L HEALTH PROGRAM (Nov. 18, 2013), <http://pnhp.org/blog/2013/11/18/obamacare-is-the-trojan-horse-for-what>. Dr. McCanne says the following about high deductible plans:

The low actuarial value plans that will dominate the Obamacare exchanges are high-deductible plans that already are or with very little tweaking will be eligible for associated health savings accounts (HSAs). HSAs work well for wealthier people who can take advantage of the tax incentives, and who remain healthy so that they can use the accumulated tax-advantaged funds in retirement. But families with more modest incomes will be selecting the low-actuarial value bronze and silver plans only because of the lower premiums. They will receive little or no tax benefit, and if major illness strikes, they may not be able to afford the out-of-pocket expenses, even if qualified for subsidies.

From a health policy perspective, the HSA component can be ignored. Except for tax incentives for the rich, the HSA is really only cash to be used for out-of-pocket payments. Even if funded by the employer, it is still paid by the employee in the form of forgone wage increases. So it is the high-deductible and not really the HSA that has such perverse consequences — patients forgoing care because of not having the money to pay the deductible, - whether having an empty pocket or an empty HSA.

What is particularly disconcerting is that it always was intended that the exchange plans be high-deductible plans, simply to control premium costs. Also, employers are now rapidly converting to high-deductible plans for the same reason. The consumer-directed advocates no longer need to hide in a Trojan horse since the deductibles are already highly visible. Right before our eyes, it has been the Trojan army of deductibles that has been conquering our health security, placing those with health care needs in servitude.

prohibitively high deductible (or premium) or dedicated savings that could pay for the deductible.

To be sure, CDHC proper is implicated in the ACA. It would be a mistake to think that CDHC proper is shut out from the exchanges. In fact, one insurance trade group anticipates that about 20% of all plans sold on the exchanges are eligible for HSAs.⁹⁰ However, according to the same trade group, HSA-eligible plans are not easy to pick out on the federal exchange.⁹¹ Whether this reflects incomplete planning on the government's part or hostility toward CDHC is unclear. It is also unclear whether prototypical CDHC plans will make a strong showing on the exchanges because of the economic demographics of the majority of those who will purchase insurance on the exchanges.⁹²

Further, the ACA requires all insurance plans, including HDHPs, to pay for preventive services with no cost-sharing.⁹³ Also, it will be harder for parents with HSAs to pay medical expenses for their young adult children.⁹⁴ Moreover, money in HSAs cannot be used to purchase over-the-counter medications.⁹⁵ Further, withdrawals from HSAs for non-medical purposes are subject to a much higher excise tax than before adoption of the ACA.⁹⁶ Also, small employers will not be able to offer the same types of high deductible plans, thus paving the way for relatively higher premium plans.⁹⁷

90. See *HSA Consulting Services Finds HSA Plans Widely Available and Attractively Priced on ACA Exchanges*, BUSINESS WIRE (Dec. 5, 2013, 7:00 AM) <http://www.businesswire.com/news/home/20131205005241/en/HSA-Consulting-Services-Finds-HSA-Plans-Widely#.Uu7hplRtb9R>.

91. See *id.*

92. But see Jim O'Connell, *ACA Megatrend #3: Consumer-Directed Health*, HUMAN RES. LEGISLATION BLOG (Sept. 16, 2013), <http://humanresourceslegislation.wordpress.com/2013/09/16/aca-megatrend-3-consumer-directed-health/> (describing the 40% tax on so-called "Cadillac" (high cost) plans and how CDHC eligible plans might be an attractive choice for employers looking to economize).

93. See *State Legislation and Actions on Health Savings Accounts (HSAs) and Consumer-Directed Health Plans, 2004-2013*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/hsas-health-savings-accounts.aspx> (last updated Aug. 2013).

94. See *id.* (reporting that the ACA requires that parents with HSAs limit expenditures from their HSAs on behalf of young adult children up to the age of 24, while parents may otherwise keep young adult children on their insurance plans up to the age of 26).

95. See Lanhee Chen, *Health Savings Accounts as Antidote to Obamacare*, BLOOMBERG (Sept. 2, 2013, 5:00 PM) <http://www.bloomberg.com/news/2013-09-02/health-savings-accounts-as-antidote-to-obamacare.html>.

96. *Id.*

97. *Id.*

IV. CONCLUSION

Consumer-Directed Health Care has had a mixed reception since its introduction in the Medicare Modernization Act of 2003. It has been a tested method for relatively healthy and wealthy people to save money and then use those savings for cost-sharing associated with their high deductible health plans. Of course, because CDHC has a significant insurance component attached to it, it allows its users to shelter themselves from the massive financial blows struck by otherwise overwhelming medical bills. It is only growing in popularity.

However, as this Article asserts, one of the hallmarks of CDHC is intentionality — the fundamental pillar that individuals and families rationally and coolly decide to reserve funds for their care, take care of themselves so they will not have to exhaust their savings, and will only use those savings for significant medical purposes in order to meet their cost-sharing obligations. The ACA, however, seems to turn CDHC on its head. Some insurers, in light of expanded benefits mandated by the ACA and other changes occasioned by it, have increased deductibles (particularly in bronze and silver plans) to levels (in some cases) that are beyond those of even traditional HDHPs. The high deductibles in ACA exchanges have turned the intentionality predicate of CDHC on its head. Instead of dispassionately choosing CDHC as their healthcare coverage model, exchange consumers are, in many cases, forced to pick a plan with a very significant deductible. Unfortunately, because the intentionality (and in many cases wealth) predicates of CDHC are not met, exchange consumers believe that the insurance offered on the exchanges amounts to nothing more than a gauzy illusion — insurance in name only. It is doubly unfortunate because high deductibles seem to be a structural problem that cannot be easily fixed without first changing the inner architecture of the ACA itself — mandated essential health benefits, underwriting prohibitions, and the like. Unless these fundamental issues are addressed, consumers who were pushed into the exchanges because of the individual mandate may find themselves without anticipated health coverage when they go to the hospital or surgery center, or they find that the prospect of purchasing and maintaining health insurance is a financially unattractive one.

