# Will the Affordable Care Act Stand?
# Assessing the Constitutional and Competitive Concerns Raised by Healthcare Reform

Remarks of J. Thomas Rosch

consumers. The net result of this program may be *higher* costs and *lower* quality health care for Medicare enrollees – precisely the opposite of its goal.

## I. Constitutionality of the Affordable Care Act

The Patient Protection and Affordable Care Act (the "Act"), a.k.a. ObamaCare, was signed into law almost two years ago to the day, on March 23, 2010.[1] The Act creates obligations on individuals, employers, insurers, and others that are designed to expand both the demand and supply of health insurance to achieve Congress's goal of "near-universal" health insurance coverage.[2]

I am no fan of ObamaCare. But, in fairness, I have to stress that many years before ObamaCare was enacted there was great concern—that I shared—about the run-up in healthcare costs in the United States. In fact, in the late 1990s and early 2000s, I represented a health insurance company and ea

The Supreme Court will decide the constitutionality of two aspects of ObamaCare.[3] The first is the individual mandate. Starting in 2014, the Act requires most U.S. citizens and legal

Florida Attorney General.[7] In that case, the Eleventh Circuit, in a two-to-one decision, held that the individual mandate exceeds Congress's powers under the Commerce Clause.[8] That decision was not a total victory for the States, however. The court held that the remainder of the Affordable Care Act was valid, including the Medicaid expansion.

In contrast, Sixth Circuit and D.C. Circuit upheld the individual mandate.[9] Both of those decisions were also by a margin of two to one.

In a final twist, the Fourth Circuit twice rejected challenges to the Affordable Care Act, but did so on procedural grounds, rather than on the merits. In the first case, the court held that the State of Virginia lacked standing.[10] In the second, the court held that a suit was barred until any penalties for violating the individual mandate were assessed.[11]

One thing that stands out about these circuit court decisions is that political persuasion was not a very accurate predictor of the results. For example, one of the judges in the Eleventh Circuit majority that struck down the individual mandate was appointed by a Democratic President.[12] Likewise, in both the DC Circuit and Sixth Circuit decisions, a well-known conservative judge voted to uphold the constitutionality of the individual mandate.[13]

---

[7] The case was initially filed by Florida and 12 other states; they have since been joined by 13 additional states, the National Federation of Independent Business, and several individuals.

[8] *Florida v. HHS*, 648 F.3d 1235 (11th Cir. 2011).

[9] *Seven-Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011); *Thomas More Law Ctr. v. Obama*, 651 F.3d 529 (6th Cir. 2011).

[10] *Virginia* ex rel. *Cuccinelli v. Sebelius*, 656 F.3d 253 (4th Cir. 2011).

[11]

Given the rather stark split among the circuits on the individual mandate, it was no

same-day audio in a handful of recent cases, such as *Bush v. Gore*, and that's what the Court is going to do here.

The Court will likely release its opinion in late June, at the end of its term. By that point, the Republican primaries will be over or nearly so, and both parties will be gearing up for their national conventions.[14]

A. The Anti-Injunction Act

The first issue that the Court will address is whether the Anti-Injunction Act prevents challenges to the Affordable Care Act at this time. The Anti-Injunction Act, which dates to 1867, bars pre-enforcement challenges to tax laws. In other words, a person cannot challenge the constitutionality of a tax until they (1) pay the tax, (2) demand a refund from the IRS, and (3) are denied that refund.

The Obama administration initially took the position that the Anti-Injunction Act barred challenges to the individual mandate because the penalty for noncompliance was a tax that would not be imposed until the 2014 tax year. Under this view, only after taxpayers filed their tax returns in early 2015 and were denied relief from the IRS could they file suit. The Fourth Circuit accepted this argument and held that the penalty for not complying with the individual mandate *was* a tax, which meant that a challenge to the individual mandate was premature.[15]

---

[14] The last Republican primaries occur on June 5 and 26, 2012. Three of the current individuals seeking the Presidency – President Obama, Mitt Romney, and Newt Gingrich – have supported individual mandates in some form.

[15] In the D.C. Circuit case, Judge Kavanaugh also reached this conclusion. *See Seven-Sky v. Holder*, 661 F.3d 1, 54 (D.C. Cir. 2011) (Kavanaugh, J.) ("I would adhere to the text of the Anti-Injunction Act and leave these momentous constitutional issues for another day — a day that may never come."). Judge Kavanaugh did not address the merits of the individual mandate. The Eleventh Circuit did not address the Anti-Injunction Act issue because neither party advanced the issue.

Since then, the administration has changed its position on this issue, and now contends that the penalty is *not* a tax for purposes of the Anti-Injunction Act.[16] Since the parties now agree that the Anti-Injunction Act does not bar the challenge, the Court appointed a prominent appellate advocate as amicus curiae to argue that the Anti-Injunction Act precludes the challenge.[17]

Amicus argues that this suit falls within the scope of the Anti-Injunction Act for two reasons. *First*, Congress enacted specific statutory language providing that

liability, assessed and collected by the IRS, and paid into the federal government's general revenues.[20]

In addition, amicus argues that the Court *must* address the Anti-Injunction Act issue because it is a jurisdictional statute. Because jurisdiction involves a court's power to hear a case, the Supreme Court has an obligation to determine whether subject-matter jurisdiction exists, even in the absence of either party raising the issue.

The States argue that the Anti-Injunction Act is inapplicable for several reasons. Under their view, the Anti-Injunction Act is not jurisdictional and is not pressed by any party to this case. Thus, the Court need not even address whether the Anti-Injunction Act is applicable. Furthermore, even if the Court concludes that the Anti-Injunction Act is jurisdictional, the States contend that it does not bar the States' challenge to the mandate for three reasons.

*First*, the States argue that the Anti-Injunction Act does not apply to states, but rather only to individuals. The statute uses the generic term "person" and contains no clear indicia to overcome the "longstanding interpretive presumption that 'person' does not include the sovereign."[21]

*Second*, the States assert that their challenge is to the mandate, not the penalty that enforces it. They argue that these are distinct provisions because numerous individuals subject to the mandate are exempt from the penalty. Thus, the Anti-Injunction Act has no bearing on their challenge, regardless of whether the penalty is a tax.

---

[20] *Id*. at 12.

[21] Brief for State Respondents on the Anti-Injunction Act at 23, HHS v. Florida, No. 11-398 (U.S. Feb. 6, 2012) (quoting *Vt. Agency of Natural Res. v. United States ex. rel. Stevens*, 529 U.S. 765, 780 (2000)).

*Finally*, the states assert that the penalty is not a tax. Congress considered and rejected proposals to impose a tax on the insured, and instead imposed a stand-alone regulatory command to obtain insurance, with a "penalty" provision to enforce it.[22]

The Administration's position is in between that of the States and that of amicus. The Administration agrees with the States that the penalty is not a tax. According to the Administration, a true "tax" carries with it a number of procedural and substantive implications under the Internal Revenue Code. The penalty under the Affordable Care Act do not match up, for the most part, with the standard rules applicable to taxes under the Internal Revenue Code.

On the other key issues involving the Anti-Injunction Act, however, the Administration sides with amicus. The Administration agrees with amicus that the Anti-Inunction Act is jurisdictional in nature and that the Supreme Court has an obligation to determine whether it applies in this case.

In addition, the Administration disputes the States' argument that their challenge is limited to the individual mandate, rather than the penalty. According to the Administration's brief, "the two provisions are inextricably intertwined; the only consequence of failing to

Finally, the Administration takes issue with the States' claim that states are not subject to the Anti-Injunction Act. According to the Administration, "states, like individuals, are 'persons' subject to the prohibitions of the [Anti-Injunction Act]."[24]

As I previously mentioned, the Fourth Circuit found that the Anti-Injunction Act barred a challenge to the individual mandate, while the Eleventh Circuit found that it did not. Most observers think that it's unlikely that the Court will find the Shared Responsibility Payment to be a tax for purposes of the Anti-Injunction Act. I was therefore surprised that last month the Court increased the amount of oral argument allotted for this issue on March 26 from 60 to 90 minutes. This is significant because the extra time may signal that the Court is interested in "kicking the can down the road," which it could do simply by determining that ObamaCare imposes a "tax" within the meaning of the Anti-Injunction Act and that the Anti-Injunction Act is jurisdictional.

B. The Individual Mandate

The second issue that the Court will address is the constitutionality of the individual mandate. The Court has set aside 2 hours of argument on March 27 for this subject. The Solicitor General will have 60 minutes to argue that the minimum coverage provision is constitutional. The States and the National Federation of Independent Businesses (a private plaintiff) will each have 30 minutes to argue that the provision is unconstitutional.

The fundamental question here is whether Congress has the power under the Commerce Clause (or its taxing power) to require individuals to purchase health insurance. Since the New Deal era, the Court has steadily expanded Congress's power under the Commerce Clause.

[24] *Id.*

However, in 1995, the Court handed down the *Lopez* decision,[25] which held that a federal criminal statute prohibiting the possession of a firearm near a school was beyond Congress's commerce power. The Court explained that the "possession of a gun in a local school zone is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce."[26] Then, five years later in the *Morrison* case,[27] the Court concluded that a statute providing for a federal cause of action for the victims of gender-motivated violence was also beyond Congress's commerce power. The Court explained that "[g]ender-motivated crimes of violence are not, in any sense of the phrase, economic activity."[28] Thus, the Court in recent years has tried to identify limits to Congress's powers under the Commerce Clause and has been willing to strike down federal statutes regulating non-economic conduct. This is significant because Justice Scalia held in *Gonzales v. Raich*[29] that growing marijuana was sufficiently close to "commerce" to justify a federal ban and because Justice Scalia's acolyte, Judge Sutton, relied heavily on that decision in upholding the individual mandate in the Sixth Circuit.

Against this backdrop, the Administration argues that the individual mandate is a permissible exercise of the commerce power for four reasons.[30]

*First*, the Administration argues that the individual mandate is an essential part of the health care reform and that the Affordable Care Act, when considered as a whole, is within the

25

commerce power. The Administration points out that in the modern era of Commerce Clause jurisprudence, the Court has never invalidated a federal provision that was "part of a comprehensive scheme of national economic regulation."[31] The Administration asserts – and the States do not dispute – that the minimum coverage provision is an integral part of the Affordable Care Act's regulation of the individual insurance market.

*Second*, the Administration argues that the individual mandate, standing alone, regulates economic conduct with a substantial effect on interstate commerce. Congress expressly found that the individual mandate regulates the way in which individuals finance their participation in the health care market. The mandate creates an incentive for individuals to finance their purchases of health care by means of insurance, rather than at the time services are provided. In other words, the individual mandate regulates the timing and manner of paying for health care services.

The Administration takes issue with the claim that the effect of the individual mandate is limited to the insurance market. According to the Administration, the Court must defer "to Congress's judgment about how to define the market it is regulating,"[32] and here, Congress has defined the relevant market as health care services. Furthermore, the Administration argues that health insurance and health care services are "inherently integrated" and that one should not be artificially isolated from the other.[33]

*Third*, the Administration asserts that the individual mandate is "fully consistent with *Lopez* and *Morrison* and the allocation of authority between the federal and state

---

[31] *Id.* at 26-27.

[32] *Id.* at 41.

[33] *Id.* at 41-42.

governments.[34] In those cases, the Court emphasized the noneconomic nature of the regulated conduct in finding it outside Congress's commerce power. By contrast, health care and the financing of health care are "quintessentially economic."[35] In addition, neither *Lopez* nor *Morrison* involved a comprehensive scheme of regulation. Finally, the Administration asserts that upholding the individual mandate would not upset the states' general police power because, as the States' concede, Congress could have reached similar results through more coercive, yet Constitutional means.[36]

*Fourth*, the Administration disputes the States' argument that the Commerce Clause cannot extend to the regulation of inactivity. The Commerce Clause states that Congress shall have the power "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[37] The administration asserts that the term "regulate" can mean to require action. In addition, the Administration argues that the States are incorrect in describing the individual mandate as a regulation of inactivity. As I've already mentioned, the Administration argues that the mandate regulates how individuals finance their purchases of health care services, something that is undoubtedly economic activity.

The Administration argues that Congress's taxing power provides an independent ground to uphold the individual mandate. The individual mandate is "fully integrated into the tax system, will raise substantial revenue, and triggers only tax consequences for non-compliance."[38]

---

[34] *Id.* at 45.

[35] *Id.* at 46.

[36] For example, Congress could have prohibited individuals without insurance from obtaining health care.

[37] U.S. Const. art I, § 8, cl. 3.

[38] *Id.* at 52.

That tax liability will be based, in part, on the taxpayer's household income, and individuals who are not required to file income tax returns for a particular year are not subject to the penalty.

The fact that the penalty is intended to adjust behavior has no bearing on whether it is a tax, according to the Administration. The Court has said that a tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed."[39] The fact that Congress used the world "penalty," rather than "tax" to refer to the payment is also immaterial.

In their briefs, the States argue that "the individual mandate is an unprecedented law that rests on an extraordinary and unbounded assertion of federal power."[40] They claim that the individual mandate is not a valid exercise of Congress's commerce power or its tax power.[41]

With respect to the Commerce Clause, the States assert that "the Constitution grants Congress the power to *regulate* commerce, not the power to compel individuals to enter into commerce."[42] The framers intended for Congress to have the power to regulate existing commerce but not the power to bring commerce into existence. The power to force individuals to engage in commercial transactions against their will was the kind of police power that was reserved for the states. If Congress can not only regulate individuals once they decide to enter into commerce but can also compel them to en

nothing left of the principle announced in *Marbury v. Madison* that Congress's powers are "defined, and limited."[43]

The States acknowledge that the Supreme Court's conception of "commerce" has expanded substantially since the New Deal era, but that the meaning of "regulate" has not undergone a similar expansion. At no time has this Court interpreted the term "regulate" to include bringing the subject into existence. "When the Constitution does grant Congress the power to bring something into existence, it does so in language that is unmistakably clear."[44] Furthermore, if the meaning of "regulate" were as broad as the Administration claims, many of the other Article I enumerated powers would be redundant.

The States also note that the individual mandate is the first ever law of its kind and point to studies performed by the non-partisan Congressional Budget Office and Congressional Research Service, both of which advised Congress that the constitutionality of the individual mandate was questionable.

The States also take issue with the Administration's argument that the individual mandate regulates the financing of the purchase of health care services. The States point out that the mandate forces individuals to *purchase* insurance but does not require the use of that insurance. In other words, insurance is distinct from the service to be insured. Furthermore, the mandate was, for the most part, directed at healthy individuals in the hopes that they would not use the insurance to obtain health care but would instead subsidize the costs of less-healthy individuals.

[43] *Id.* at 11 (quoting *Marbury v. Madison*, 5 U.S. 137, 176 (1803)).

[44] *Id.* at 20. For example, Congress has the power to "establish Post offices" and to "constitute Tribunals inferior to the Supreme Court." U.S. Const, art. I, § 8, cl. 7, 9.

The States respond to the Administration's comprehensive-regulatory-scheme argument by pointing to a number of cases where the Court struck down unconstitutional laws even though they were integral components of otherwise-permissible regulatory schemes.

With respect to Congress's taxing power, the States reiterate that they are not challenging the penalty, but rather the mandate. Furthermore, the States assert that Congress made a deliberate decision not to enact a tax and repeatedly referred to the mandate's enforcement mechanism as a "penalty." More importantly, a payment operates as a penalty because it is imposed only for an improper act. In contrast, a tax provides for the general support of the Treasury. Penalties do not become taxes "simply because they are housed in the tax code and collected by the Internal Revenue Service."[45]

The States conclude by observing that if the individual mandate is upheld, there is no principled reason why Congress cannot compel individuals to engage in a wide range of commercial activities. This has sometimes been called the "Broccoli issue" on the theory that the government could require the daily purchase of Broccoli to reduce health care costs related to obesity. Likewise, the government could mandate the purchase of a Chevy to aid the government's automotive bailout.

### C. Severability of the Individual Mandate

The third issue that the Court will address is whether the individual mandate is severable if it is found to be unconstitutional, or instead whether other parts of the Act would also have to fail. The Eleventh Circuit held that the individual mandate was completely severable and left the remainder of the Act standing. In contrast, the district court struck down the entire statute

[45] *Id*. at 60.

because the individual mandate was so closely tied to everything else in the Affordable Care Act.[46]

The Supreme Court will hear 90 minutes of argument on this issue on March 28. The States will have 30 minutes to argue that the entire law must be invalidated. The Solicitor General will have 30 minutes to argue that only the guaranteed issue and community rating provisions in the Act are inseverable from the minimum coverage provision. Court-appointed amicus will argue that the minimum coverage provision is completely severable from the rest of the Act.[47]

The States argue that severability is a remedial inquiry that turns on legislative intent. According to the States, the question is *not* whether the remainder of the Act, or some portion of

The Administration argues that the States lack standing to challenge any provisions of the Act that do not apply to them, citing *Printz v. United States*.[50] Under that view, only the severability of the Medicaid expansion could properly be decided by the Court because the States are subject to that provision. The remaining provisions of the Affordable Care Act only affect third parties, such as insurance companies.

If the Court does address the severability issue, the Administration asserts that only the guaranteed issue and community rating provisions of the Act are inseverable from the individual mandate and must therefore be struck down. These provisions require insurers to offer the same premium to all applicants of the same age and location without regard to most pre-existing conditions (other than tobacco use).

According to the Administration, the "Court has repeatedly held that, 'when confronting a constitutional flaw in a statute,' a court must 'try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact.'"[51] The Administration argues that most of the other provisions in the Affordable Care Act can operate effectively without the individual mandate and will further Congress's goal of expanding affordable coverage. In contrast, the guaranteed issue and minimum coverage provision depend on the individual mandate; without the mandate, "healthy individuals would defer obtaining insurance until they

---

invalidating the entire Act. Without the individual mandate or Medicaid expansion, the Act would do almost nothing to increase insurance coverage." *Id.* at 50-51.

[50] 521 U.S. 898 (1997).

[51] Brief for Respondents (Severability) at 27, Nat'l Fed. Indep. Business v. Sebelius, Nos. 11-393, 11-400 (U.S. Jan. 2012) (quoting *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010)).

needed health care,"[52] resulting in higher premiums and fewer insured lives—the opposite of Congress's intentions.

Court-appointed amicus argues in support of the judgment of the Eleventh Circuit that the individual mandate is severable from the remainder of the Affordable Care Act.[53] Amicus claims that the Court generally "refrain[s] from invalidating more of [a] statute than is necessary."[54] The only exceptions are where the remaining provisions of the statute are not fully operative as a law, or it is evident that Congress would not have enacted the remaining provisions.

Given the States' and the Administration's agreement that the guaranteed issue and community rating provisions are not severable, amicus directs most of its attention to those provisions. Amicus argues that these requirements were the core reforms to the insurance market in the Act and that they were designed to make health insurance affonistro(dllsever-2.3 TD -4 .0h)5

## D. Medicaid Expansion

The final issue that the Court will address is whether the Affordable Care Act's expansion of the Medicaid program is constitutional. This argument has not been successful in any of the lower courts. The Court will hear one hour of argument on this issue on March 28, with each side having 30 minutes.

The States' challenge to the expanded Medicaid coverage rests on what is known as the coercion theory, a doctrine the Court has addressed only a handful of times. The Supreme Court

with several other aspects of the Act, where Congress provided a "Plan B" if any states declined to participate.

In addition, the States argue that refusing to go along with the Medicaid expansion would threaten states with the loss of "every penny" of federal funding under the single largest grant-in-aid program in existence—literally billions of dollars each year.[57] For prior expansions of Medicaid, Congress had offered additional funds to states that agreed to accept additional obligations. Here, however, Congress threatened to withhold funds from states that refuse to implement the Medicaid expansion.

The Administration argues that the Affordable Care Act's expansion of the Medicaid program is a constitutional exercise of Congress's Article I authority. According to the Administration, Congress has broad authority to attach conditions to federal spending.

From the outset, Congress specifically reserved the right "to alter, amend, or repeal any provision" of the Medicaid Act,[58] and Congress has on several occasions required states to accept an expansion as a condition of continued participation in the overall Medicaid program. The Administration also points out that the Affordable Care Act will result in a very small increase in costs to the states, due to the federal government covering between 90 to 100 percent of the expansion. There is no dispute that the states are free, as a matter of law, to withdraw from the Medicaid program and turn down its funding.

The Administration says that the States' argument that Congress itself passed the Act on the understanding the states could not leave Medicaid is factuTc -.,-To(i)-2gw5pstateswithdraew

from Medicaid, individuals that could not afford insurance would be exempt from the individual mandate penalty.

## II. Accountable Care Organizations

I'd now like to turn to another aspect of ObamaCare—the Medicare Shared Savings Program. This part of the Affordable Care Act promotes the formation and operation of Accountable Care Organizations ("ACOs") to serve Medicare fee-for-service beneficiaries. Under this provision, "groups of providers . . . meeting the criteria specified by the [Department of Health and Human Services] may work together to manage and coordinate care for Medicare . . . beneficiaries through an [ACO]."[59] An ACO can share in a portion of any savings it creates if it also meets certain quality performance standards published by the Centers for Medicare and Medicaid Services ("CMS"). The Act requires that ACOs that wish to participate in the Shared Savings Program enter into an agreement with CMS for at least three years and agree to accept at least 5,000 beneficiaries assigned by CMS.

is not subject to sharing in losses. Under the two-sided track, an ACO receives up to 60% of any savings but must absorb a portion of expenses that exceed a certain benchmark. An ACO participating in the two-sided track can reduce its liability for losses by hitting certain health care quality benchmarks. An ACO can have only one agreement period under the one-sided model;

structure and the same clinical and administrative processes as it uses to qualify for and participate in the Shared Savings Program. This is for reason treatment will apply to the ACO for the duration of its participation in the Shared Savings Program.

With that background in mind, I would like to share with you two concerns I have as an enforcer about the Shared Savings Program. The first is that the Program is unlikely to result in any overall health care cost savings. The second is that the government may not be able to accurately monitor the quality of health care services by participating providers, which may lead to providers reducing the quality of their services in order to qualify for the shared savings rebates.

A. ACO Cost Savings

On its face, the Shared Savings Program sounds promising: using financial incentives to reduce costs and improve the quality of care. Who could be against that? Nevertheless, I am skeptical that ACOs will actually lead to any net health care cost savings. The available evidence suggests that the cost savings to Medicare will be very small to nonexistent, and there is a substantial risk that any reduction in Medicare expenditures will simply be shifted to payors in the commercial sector.

The Congressional Budget Office projected that Medicare would save $5.3 billion over ten years from the formation of ACOs.[64] Over the same period, total Medicare spending is projected to be over $7 trillion.[65] Thus, the cost savings from ACOs, assuming that these

[64] Congressional Budget Office, Budget Options, Volume I: Health Care at 72-74 (Dec. 2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf. In a more recent analysis, CMS estimated $470 million in Medicare savings in the first four years of the program. *See* Final CMS Regulations, *supra* note 60, at Table 8.

[65] 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at Table III.A1 (2011), *available at* https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf

organizations are actually effective in improving quality and containing costs, represent less than one tenth of one percent of expected Medicare expenditures over the next decade. In other words, even under the most optimistic scenario, the savings to Medicare from the ACO program are no more than a rounding error.

Yet even the CBO's modest cost savings projections are likely overstated. CMS has been running what is known as the Physician Group Practice (PGP) Demonstration for the last several years.[66] The PGP Demonstration created incentives for physician groups to coordinate care delivered to Medicare patients, rewarded them for improving the quality and cost of services, and created a framework for collaboration with other providers – in other words, they've done a trial run of the ACO program. The results were nothing to crow about. While all participating physician groups improved the quality of their services based on certain benchmarks, the cost savings were, in CMS's own words, "minimal."[67]

occurred.[69] In other words, CMS acknowledged that reduction in Medicare expenditures at these practice groups might have occurred even absent the financial incentives of the project.[70]

There is also a substantial risk that any reduction in costs due to the Shared Savings Program will simply be borne by commercial payors. The commercial sector already subsidizes providers accepting Medicare and Medicaid payments for certain services. The ACO program may exacerbate this trend by causing providers to shift more of their costs to commercially insured patients in order to qualify for the Medicare cost-reduction bonuses. This cost shifting may be facilitated by the enhanced market power of some ACOs in the commercial market. One recent study showed that this is precisely what happened in California as independent practice associations flourished there.[71] In short, even if ACO participants demonstrate that they are lowering costs to Medicare, that will say nothing about the net changes in health care costs for the country as a whole.

B. ACO Service Quality

Another problem with the Shared Savings Program is the way in which the quality of care of participating ACOs is measured. CMS's regulations link the amount of shared savings an ACO can receive (and in certain instances the losses it may be accountable for) to its performance on 33 quality measures.[72]

---

[69] PGP Report, *supra* note 66, at 14.

[70] ACOs in the Shared Savings Program will have smaller financial incentives to reduce costs than providers in the PGP Demonstration had. PGP Demonstration participants could receive a rebate of up to 80% of the cost savings, while ACOs will only receive up to 50% for participation in the one-sided model or 60% in the two-sided model.

[71] Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 Health Affairs 699 (2010).

[72] Final CMS Regulations, *supra* note 60, at 67,802.

Accurate quality measurements are critical for several reasons. First, by accurately measuring an ACO's quality, CMS can ensure that cost savings are the result of improved provider coordination and adherence to best practices, rather than through a reduction of needed services. Recall that the Shared Savings Program rewards ACOs that achieve cost savings. Thus, both ACOs and their participating physicians have an incentive to undertreat their patients to earn the shared savings rebates. CMS intends to use the quality metrics to ensure that ACOs will not scrimp on needed services in order to qualify for the shared savings rebates.

In addition, the quality of care provided by a particular ACO may be relevant to an antitrust inquiry of that ACO. If an ACO can demonstrate that it has scored well on the CMS quality metrics (and has lowered costs), it may have a defense to an antitrust challenge to the formation of the ACO or its contracting practices in the commercial market.

Finally and most importantly, lives are at stake. If the Shared Savings Program leads to inferior health outcomes, Congress and CMS need f]soTD emknow sost practisat ACOs

through targeted marketing campaigns or through recruiting physicians that have healthy or compliant patients.

The second problem with CMS's 33 quality metrics is that they suffer from a number of inherent limitations. Seven of the quality metrics are based on patient surveys. It's no secret that designing an accurate survey is not easy, and CMS has acknowledged that "survey mode and methodology can affect results."[77] For example, patients with limited English skills are unlikely to complete written surveys. Furthermore, survey results are influenced by a variety of subjective factors, including patients' attitudes toward their own health. Imagine a physician that repeatedly urges a patient to get stop smoking, but the patient refuses. Despite following recommended guidelines, the doctor may receive

outside the ACO.  As a result, th

real risk that providers will have the incentive and ability to reduce the quantity and quality of needed services to Medicare beneficiaries without detection from CMS.

That brings me to my fundamental objection to ObamaCare, namely that it imposes more government regulation and control over a marketplace that is functioning poorly in large part due to existing over-regulation. Assuming it is upheld, the Act may lead to greater coverage but with the tradeoffs of higher costs to consumers, employers, and the government, and forcing some consumers to purchase a product they don't want. The better approach, in my view, would have been to eliminate, to the extent possible under our federalist system, the barriers at the state and federal level to a truly competitive health care marketplace—and here I am talking about the barriers posed by the McCarran-Ferguson exemption to the antitrust laws. This would have lowered costs to consumers, improved health care quality, increased innovation, and increased coverage—all at little to no cost to the federal government or consumers.