Super-Sizing Health Reform

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William M. Sage, Putting Insurance Reform in the ACA's Rear-View Mirror, 51 **Hous. L. Rev.** 1081 (2014).

For this Jot, I wanted to review recent or forthcoming scholarship on the bombshell D.C. Circuit *Halbig v. Burwell* decision, now awaiting en banc rehearing and buttressed by a similar decision from an Oklahoma District Court in Pruitt v. Burwell. But the only articles that I could find were Michael Cannon and Jonathan Adler's piece that started the whole mess and a succinct rebuttal in *State Tax Notes*. My search, however, did turn up a terrific Commentary by Bill Sage, which I had somehow missed in my routine reading. Appropriate at the time that Sage wrote his Commentary, Sage gave *Halbig* a mere one-line, one-footnote reference in his insightful perspective on the aims and limits of recent U.S. health care reform efforts. Thankfully, it was *Halbig* that enabled me to discover Sage's piece.

Necessarily, given the Affordable Care Act's 2,400-page length and complexity, many of us have focused our writing on discrete aspects of the law. Sage instead offers a cogent flyover, bringing to bear his years of experience in this business, to explain what is and isn't working in the ACA. Stepping back from the details, Sage identifies the ACA's ambitious agenda not only to achieve near-universal health insurance coverage but also to reform the health care delivery system and improve population health. He commends this "triple aim," emphasizing that insurance reform is, and must be, just the beginning of a successful health policy agenda.

Most commentaries have focused on the first aim—health insurance reform. But Sage urges that if we stop there we cannot hope for any real change. Sage aptly analogizes the second aim—health care delivery—to a ballpoint pen, representing health care providers' largely unrestrained discretion to order more and more health care services and products. The third aim—population health—is colorfully analogized to a French fry, representing the public's unchecked appetite for high-calorie, highly processed convenience foods and distaste for physical activity. Addressing the first aim "simply" (would that it were so simple!), by getting the remaining 15% of the U.S. population insured, will do little to address the pen and French fry problems. But combining all three aims in one large statute could potentially derail the entire effort. Sage (and we) hope not.

Sage identifies three underlying assumptions that stymie the United States' health reform efforts. First, the ACA hews a managed competition approach, combining a patchwork of public and private structures to deliver health care, rather than making the leap to a single-payer approach. Second, the law operates from the premise that there is enough money in the system and that universal coverage with a minimum essential package of benefits will distribute those funds more efficiently. Third, the public accepts the necessity of a social safety net for certain segments of the population and assumes that those needs are valid, unmet, and properly delivered through existing program design. Sage offers those three explanations for the ACA's shortsighted strategy of trying to address the underlying problems with aims two and three, health care delivery and population health, largely through aim one, health insurance reform.

As things have played out, of course, health insurance reform itself has faced multiple unanticipated challenges, including obstructionist, federalism-propounding states opting for federally, rather than state, run health insurance marketplaces; major technology glitches with rollout of the healthcare.gov website; President Obama's promising what he couldn't really promise—that health insurers would not drop subscribers; the Supreme Court's *NFIB v. Sebelius* decision upholding the individual mandate as a tax while striking down Medicaid expansion as exceeding congressional spending power; and, most recently, in *Halbig* and *Pruitt*, the courts' acceptance of a seemingly laughable argument that federal subsidies to make health insurance more affordable would be available to only a portion of the nation's population, depending largely on the politics of their statehouses and capitols.

If we learned anything from the policy debates around the ACA, it is that everything old is new again; there are few new ideas in health reform. And Sage's article does not purport to offer a wholesale, novel rethinking of approaches to the triple aim. But what I most enjoyed about his Commentary were the novel nuggets (including but not limited to the colorful ballpoint pen and French fry analogies) that connect apparently disparate dots in existing thinking about these problems.

For example, Sage notes that Medicaid now competes with education for the biggest share of state budgets, and that tension necessarily undermines demonstrated synergies between education and health. Instead of pitting those agendas against each other, policymakers need to recognize that healthy children learn better, and that better-educated people live healthier lives. He also offers a different way of framing the ACA's much-touted health insurance reforms, including guaranteed issue, community rating, mandated benefits, and mandatory participation, as about not just expanding the risk pool (as the standard narrative goes) but also encouraging insurers and insureds to think about health insurance as prepaid health care, rather than insurance against risk. That rethinking, we are left to surmise, operates as a mental down-payment on more ambitious future reforms, such as a single-payer system. For now, although Congress declined to consider a Canadian or European-style national health insurance program, Sage observes that the ACA was enacted in similar historical climate as Social Security and Medicaid, namely, the country's most severe economic downturn since the Great Depression. The ACA, he concludes, "conveyed solidarity, if not uniformity" with the view that health reform is a national problem requiring a national solution.

Sage concludes with cautionary optimism about the future of health reform. The ACA's triple aim is the right idea. But health insurance reform will not succeed without serious commitment to changing payment systems, improving information flow, rationalizing pricing, and reducing barriers to innovation and efficiency. Moreover, we must take steps to improve our health, combining both communitarian public health and libertarian individual responsibility approaches, and in so doing, must avoid bogging down in the partisan politics that so far have derailed insurance reform.

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