Backgrounder

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Implementing Obamacare: A New Exercise in Old-Fashioned Central Planning

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Abstract: *Obamacare—the massive health care law passed in March—constitutes the largest expansion of government since the Great Society. Americans have voiced their strong opposition, but the Obama Administration is determined to force-feed the new medicine. The Administration's vision of health care is based on the premise that the federal government can—and must—control the details of health care financing and delivery across the country. The Patient Protection and Affordable Care Act (PPACA) is the scaffolding for this control. The new law gives the Administration extensive authority to achieve broadly outlined goals, allowing it to control every aspect of health care finance and delivery and to impose its view of how the health care system should operate. The Administration will issue volumes of complex regulations. Health care is being bureaucratized and politicized. The structure of the health care system will be determined by one central authority, reducing flexibility and denying Americans the ability to make their own choices. Americans will have to obtain health insurance and health care based on what the federal government deems best for them.*

Americans are confronted with the largest expansion of government in almost half a century. President Barack Obama and the congressional Democratic leadership passed massive health care overhaul legislation in March 2010 by the narrowest of margins. Despite the Administration's ongoing efforts to persuade Americans that the medicine is good for them, well over half the country refuses to swallow it.[1]

Talking Points

- Americans are confronted with the largest expansion of government since the Great Society. The Patient Protection and Affordable Care Act (PPACA) imposes intrusive federal control of America's health insurance and health care.
- PPACA is based on the premise that the federal government can—and must—regulate health care.
- Despite the Obama Administration's ongoing efforts to persuade Americans that the medicine is good for them, well over half the country refuses to swallow it.
- PPACA sets ambitious general goals and gives the Administration broad authority to carry them out. The Administration's exercise of this authority will determine whether private health insurance survives and will dictate how health care is delivered. PPACA bureaucratizes and politicizes health care.
- Although Americans' circumstances and needs vary greatly, the Administration's determinations will impose one-size-fits-all requirements on all Americans and reduce their ability to make individual health care choices.

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Underlying this objection is an uneasy feeling that while the legislation may help uninsured Americans obtain coverage, there are more direct and less expensive ways to do this. Americans sense that the Administration used the uninsured as a tool to force-feed a larger agenda to the entire population. Their unease is well justified: The Patient Protection and Affordable Care Act (PPACA)[2] imposes intrusive federal control of the American health insurance and delivery system.

Administrative Action. Enactment of PPACA is the first step to this control; the law must be implemented by administrative action. While it is detailed in some instances, PPACA is largely aspirational; it directs the Administration to achieve various universally desired goals—better quality of health care, improved access to care, and increased efficiency of delivery. It constructs the scaffolding of federal control and gives the Administration very broad authority to achieve these aspirations.[3] Each of the many actions taken to implement it will determine the shape of that control. Implementation will be technically difficult and politically charged.

PPACA is based on the premise that the federal government can—and must—regulate the details of the health care financing and delivery systems. With its enactment, health care has been thoroughly bureaucratized—since it must be implemented by public servants—and politicized by the Administration and Congress. Bureaucratization and politicization are the inevitable characteristics of government action.

Health care is infinitely complex. Patients and those who provide and pay for their care engage in millions of discrete but interrelated transactions. It is hubristic to believe that the federal government can determine the one "right" approach to organizing the health care system. Yet PPACA attempts to do just that. PPACA represents an effort to impose a uniform template on the health care system. It significantly reduces the ability of patients and providers to choose how to accommodate their different circumstances and individual desires.

PPACA gives the Administration a huge, and ultimately impossible, task. As in virtually every other instance of government central planning throughout history, PPACA's single-minded reliance on federal control will prove counter-productive. But the actions the Administration will take to try to achieve the goals of PPACA will affect every American's health care. The link between Administration actions and changes in health care delivery will not always be apparent to patients and their providers: The government's actions will largely be hidden behind the screen provided by the various actors it controls—insurance companies, states, and the new purchasing exchanges. Behind that screen, officials of the federal government will be pulling these actors' strings.

As the Administration issues regulations under PPACA, attention will be focused on the particulars of individual promulgations; the fact that each regulation is part of a larger scheme of control should not be overlooked. This paper focuses on some of the most important avenues made available for the Administration to control American health care; there are many others as well.

Federal Control of Private Health Insurance

PPACA requires the Administration to decide what type of insurance can be sold through the new American Health Benefit Exchanges, which will be in operation in January 2014 to offer insurance to individuals and employees of small employers.[4] Government subsidies are available only for policies

1. 60 percent of American voters believe that repeal of the law would benefit the economy. Overall support for repeal among voters has ranged from 52 percent to 63 percent. "Health Care Law," Rasmussen Reports, August 16, 2010, at *http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/health_care_law* (August 17, 2010).
2. PPACA is P.L. 111-148. For ease of reference, "PPACA" as used here also includes the Health Care and Education Reconciliation Act, P.L. 111-152, which amends P.L. 111-148 in certain respects.
3. PPACA requires HHS to list "all the authorities provided to" it by the new law prior to April 22, 2010 (Section 1552). The list would be lengthy and informative. HHS, however, has not been willing, or able, to supply this information. At the April deadline, HHS posted a copy of PPACA's table of contents on its Web site. It still has not listed its new authorities.

purchased through an exchange. A health plan must be a "qualified health plan" in order to sell on the exchange. A qualified health plan must provide the "essential health benefits package."[5] At the core of this package are "essential health benefits."[6]

Need to Define. PPACA stipulates that in defining "essential health benefits," the U.S. Department of Health and Human Services (HHS) must include at least 10 enumerated "general categories" of care: emergency services, hospitalization, laboratory services, maternity and newborn care, prescription drugs, ambulatory patient services, mental health and substance use disorder, rehabilitative and habilitative services, preventive and wellness services and chronic disease management, and pediatric services. This is a simplistic and almost random listing of health care categories. It mixes sites of care and kinds of treatment. It fails to include many services, such as diagnostics and medical devices. HHS is given catchall authority to add other "general categories," without any stated limitation.[7]

The law also requires that HHS's definition of "essential health benefits" "reflect an appropriate balance among" the general categories of services. A "balance" implies a quantitative approach; a balance can be struck only by defining the amount of each service. The definition thus must state what percentage of the required insurance coverage each of the categories of care should represent. This is impossible; no one can prospectively estimate what the share of a plan's coverage should be for any of the categories. The effort is made more difficult by the overlap of the categories: for example, hospital services also include prescription drugs.

Impossible Task. The purpose of defining "essential health benefits" is to ensure a common level of coverage by insurers as set by the Administration. Although HHS can, of course, produce a piece of paper (or, more likely, hundreds of pages of regulation) purporting to define the term, in reality this will not provide the real-world uniformity of coverage contemplated by PPACA. HHS has an impossible task.

On the one hand, the definition could stay at the general level of the statute: It could recite the categories listed in the PPACA and whatever categories HHS decides to add, such as, presumably, diagnostic services. But listing the various categories of services that insurers must cover says little about what a plan must actually cover.

On the other hand, if the definition lists particular services that must be covered, it starts down a road of infinite complexity and overwhelming detail. If, for example, diagnostic services are included, will the definition list MRI scans as a required diagnostic procedure? Even if it does, the definition would be meaningless unless it goes on to specify under which conditions an MRI must be covered. Which symptoms require an MRI scan rather than a less-expensive x-ray? How long must the patient have experienced the symptoms? Similarly, with respect to hospitalizations—for which conditions and under what circumstances would insurers be required to provide coverage? When it comes to cancer patients, are all chemotherapies included as part of the "essential health benefits"? Are only some included? It is impossible for HHS to define the circumstances for each and every treatment.

4. Section 1311(b), (d). States may permit insurance to be offered to large employers through the exchanges beginning in 2017, Section 1312(f).
5. Section 1301.
6. Section 1302. Although the terms are confusingly similar, "essential health benefits" is a different concept from "minimum essential coverage." The latter is the standard for determining what coverage individuals must maintain and large employers must provide to avoid penalties (Section 1501(b), adding IRC Section 5000A(a); Section 1513(a), adding IRC Section 4980H(a)). Pursuant to the definition of "minimum essential coverage," these mandates can be met and penalties avoided by offering/maintaining any insurance sold in the state in the individual, small, or large group markets (new IRC Section 5000A(f)(1) and (2)). On the other hand, to be sold through an exchange and to be eligible for subsidy, the plan must cover the "essential health benefits." The confusion about the application of the two terms is compounded by a seemingly contradictory provision: Section 2707 of the Public Health Service Act, added in Section 1201, requires insurance in the individual and small (but not large) group markets to include "essential health benefits."
7. Section 1302(b).

A general standard of medical necessity could be grafted into the definition, but that would just beg the question of what is medically necessary under different conditions. A plan could satisfy the requirement merely by issuing a policy that repeats the conclusory terms in which HHS would have defined "essential health benefits."

HHS must choose from the great variety of preventive measures and wellness programs as well. It must decide whether to include visits to spas, exercise classes, or a personal trainer, and whether to include acupuncture, traditional medicine, and chiropractic medicine.

A Mushy Definition. Advocates of particular services—patients, providers, and suppliers—will lobby for their explicit inclusion in the definition. This will occur both at HHS and in Congress, and will result in an *ad hoc* hodgepodge of discrete provisions covering specific services that the Administration chooses to include.

What is likely to emerge is a pudding of a definition—some general categories and some specifics. The product is not likely to represent a meaningful common set of benefits. At the same time, however, in directing HHS to fashion this definition, PPACA gives HHS *undefined and unchecked* power to go to any level of detail. HHS has the power to choose from the entire universe of diseases, diagnostics, and treatments and to dictate what must be included in the insurance sold in the exchanges.

The Goldilocks Standard. PPACA offers one apparent standard to guide HHS in its quixotic assignment, but it is as broad and as vague as the concept of "essential health benefits" itself. HHS's definition, PPACA stipulates, must be "equal to the scope of benefits provided under a typical employer plan." "Equal to" is significant—as for Goldilocks, it must be just right, not more or less. The Chief Actuary of HHS's Centers for Medicare and Medicaid Services is required to certify this equivalence (although PPACA does not state whether HHS's definition is effective if he does not).

The Department of Labor is required to conduct a survey of employer-sponsored coverage to identify the benefits provided in a "typical employer plan." This exercise again raises the question of how insurance coverage is measured. Does the survey examine only what an insurance plan covers on paper in broad terms? Or will it probe beneath the surface and determine how the nominal coverage is applied in practice? Will the Department of Labor or HHS do this for every plan surveyed?

The notion that there is a "typical" plan is, of course, naive. Large, unionized industries typically offer more insurance than do sectors characterized by small, non-unionized firms. Just as the Davis–Bacon Act requirement that federal contractors pay the "prevailing wage" has been applied to make the union scale the prevailing wage, the Administration could assert that the most comprehensive plans are "typical." The result of this exercise is likely to be that small employers and individuals buying insurance through the exchanges will be required to purchase policies that are more expensive than their current plans.[8]

The Administration thus is given vast, but undefined, power to determine the care that must be covered by insurance plans. As a practical matter, it will determine what kind of care is available to Americans who purchase insurance through the exchanges, how much the insurance will cost, and the extent of taxpayer subsidies. Whatever result it reaches will set a single standard—at least on paper—for everyone, despite the great variety of individual circumstances and desires. This is a fool's errand. A centralized authority cannot properly determine for every patient and every condition what must be provided, and when. But PPACA requires HHS to do just that. Its decisions will replace both individuals' choices and employers' judgments, and set the new contours of American health insurance.

8. It is not clear how the need to update the definition as technology changes squares with the requirement of equivalence with the typical employer plan. How long does the initially identified typical employer plan serve as the touchstone? Will the Administration periodically re-calibrate by conducting periodic surveys to re-identify the typical employer plan?

Federal Control of Private Health Insurance Companies

PPACA gives the Administration the power to control every aspect of private insurance sold in the exchanges. It requires the insurers to take all applicants and to charge all members in an area the same premium regardless of risk (with exceptions for family coverage, tobacco use, and age).[9] Although the law does not give the Administration explicit authority to regulate the level of insurance premiums, through a web of reinforcing provisions, it gives the Administration the *de facto* power to do so.[10]

Rate-Setting by Denunciation. The Administration is required, beginning with plan year 2010, to put in place a process to identify "unreasonable" increases in premiums and to require the insurer to post a justification for the increase online before its implementation. This constitutes guilt by allegation. PPACA does not provide a process for the insurer to explain the reason for the increase before it is branded unreasonable. Nor does it provide any standard for what qualifies as unreasonable. After HHS has labeled an increase "unreasonable" it is too late for the insurance company to defend the increase. The insurer's explanation at this point, which must involve complex economic facts, may not have much effect on consumers. The threat of labeling an increase "unreasonable" gives the Administration unchecked power to extract concessions from insurers and, thus, to control how they operate.[11]

The scope for the Administration to regulate by denunciation broadens in 2014. PPACA directs the Administration to "monitor" *all* premium increases—not just those labeled as unreasonable.[12]

Rate-Setting Through Exchanges. PPACA also allows the Administration to use its control of the exchanges to set rates. The exchanges can—and indeed may be required to—act on the federal government's characterizations of a premium increase, however political and uninformed these characterizations may be. Since the Obama Administration has sought, but does not have, authority to control premiums directly, it can be expected to use its power over the exchanges to impose controls.

States are required to organize exchanges. Exchanges must comply with federal standards. If a state's exchange is not acceptable to HHS, or if the state does not organize one, HHS will create one for that state.[13] The federal government controls the exchanges.

PPACA appropriates $250 million for grants between 2010 and 2014 to support state review of premium increases.[14] A state that receives a grant is required to make recommendations to the state's exchange on whether it should exclude a plan that has "a pattern or practice of excessive or unjustified premium increases."[15]

The exchanges must require plans to provide a justification for "any" premium increase before it is

9. Sections 2701–2708 of the Public Health Service Act, added in Section 1201.
10. The President sought such authority in February 2010 as part of the effort to combine the House-passed and Senate-passed bills, but this proposal did not fit under the rules for the reconciliation process and was not included in the reconciliation bill.
11. Section 2794(a) of the Public Health Service Act, added by Section 1003. This power is not limited to insurers selling in the exchanges.
12. Section 2794(b) of the Public Health Service Act.
13. Section 1311.
14. Section 2794(c) of the Public Health Service Act. HHS announced the first grants on August 16, 2010, totaling $46 million; 16 of the grantees said they would use the funding to seek additional legislative authority for rate review; 22 plan to expand the scope of their current review authority. Press release, "$46 Million in Grants to Help States Crack Down on Unreasonable Health Insurance Premium Hikes," U.S. Department of Health and Human Services, August 16, 2010, at *http://www.hhs.gov/news/press/2010pres/08/20100816a.html* (August 24, 2010).
15. Section 2794(b)(1) of the Public Health Service Act. The exchanges begin operation in 2014; it is unclear how money received before then can support activities with respect to insurance premiums after the grants have ended. Nor is it clear how long this tail requirement lasts. If a state receives grant money between 2010 and 2014, will the state be required to make recommendations to the exchange indefinitely?

implemented. The exchange must take this into "consideration," as well as any recommendation from the state concerning patterns of excessive or unjustified increases, in deciding whether the plan can be sold.[16]

The requirement that exchanges consider whether a plan's increased premium disqualifies it from the exchange could prove to be highly elastic. The federal government might require that the exchanges give weight to its own pronouncement that a given increase is "unreasonable." It might require that the exchanges' consideration of these various statements and recommendations result in a decision to exclude the insurer from the exchange if it does not reduce its premium. Exchanges that do not do so are likely to receive negative marks on the tally sheet maintained by their federal keepers. The Administration no doubt will be tempted to follow this route in light of its professed desire to regulate premiums. Once it has started, it will have to issue regulations on what is a reasonable premium increase, putting it in the position of engaging in generalized, prospective rate-setting.

Control Over Management. PPACA determines the activities that an insurer can undertake, through a seemingly technical requirement. It stipulates that plans must spend at least 80 percent (in the small group or individual market) or 85 percent (in the large group market) of their premium income for payment of claims for "clinical services" and for activities to improve the quality of care.[17]

This medical loss ratio (MLR) requirement limits the amount that insurers can spend on administrative and other activities that are not counted as part of claims payment or quality improvement. It also limits how many employees insurance companies may hire and what they are paid.

If insurers spend more than 15 percent or 20 percent (depending on the size of the market) of their premium income on non-qualifying activities, they must return the excess to their members. In effect, any non-qualifying expenditure is paid twice—once to the employees who worked on the non-sanctioned activity above the limit, and then to the members of the plan. Ironically, if an insurer develops higher cost policies and generates more premium revenues, the denominator in this calculation increases and the insurer can spend more, in absolute terms, on these other activities. This provision thus discourages the development of policies with mechanisms to reduce claim payments and thus to lower premiums.

Insurers undertake many activities to reduce costs and increase efficiency, and to compete in the marketplace. They organize provider networks and develop systems and hire experts to detect fraud. They may provide incentives to providers to adopt electronic health information technologies. If costs like these are not accepted for purposes of calculating compliance with the MLR requirement, plans will be discouraged from undertaking them—to the detriment of efficient operations and cost containment. Competition among insurers and choice for consumers will be reduced if advertising costs and communications with policy holders are not qualified.

The MLR requirement could have a spillover effect on providers. Claim payments count toward the MLR requirement only if they are reimbursements for "clinical services." HHS will have to decide whether every claim presented by a provider is deemed to be for clinical services or whether the statute requires that their claims be disaggregated. Do, for instance, claims made for counseling patients on preventive guidance count as "clinical services"? Will HHS's implementation of this PPACA provision be tied to the definition of "essential health benefits"? Any attempt by HHS to define "clinical services" and limit the claim payments that are included in the required MLR payout would entail massively complex and intrusive auditing and regulation on the provider level.

PPACA directs the National Association of Insurance Commissioners (NAIC) to establish, subject to "certification" by HHS, "uniform" definitions of which expenditures are counted as part of claims payment and quality improvement and to develop

16. Section 1311(e)(2).

17. Section 2718(b) of the Public Health Service Act, added by Section 1001.

standardized methodologies for measuring them. The NAIC is an organization of state insurance commissioners. PPACA's delegation to a private organization to set critical definitions is unusual. It is unclear how much authority HHS can exercise through the unspecified certification process.

Whether the NAIC acts independently or HHS influences the result through the certification process or otherwise, these entities together have broad authority to determine what activities insurers may undertake, as well as their ability to earn a profit.[18] In addition, PPACA gives the Administration discretion to adjust the 80 percent MLR requirement for plans sold in the individual market if enforcement of the limit would destabilize that market. The Administration is also given authority to change the MLR limit if organization of the exchanges in 2014 makes the individual market volatile.[19] The Administration thus has the power to determine whether insurers are able to participate in the individual market.

Pronouncing Value: The Ultimate Control

The Administration and the federally supervised exchanges are also given life-or-death power over insurers in a more definitive way: They are authorized to opine on each plan's value and, consequently, to significantly guide consumer choice.

Developing "Methodology." HHS is required to develop "a methodology to measure health plan value."[20] PPACA stipulates the factors that must be considered in measuring value, but in doing so highlights the imponderable sub-issues.

The methodology must take into account the "overall cost" of the plan to enrollees; the quality of care provided (Providers, not plans, provide care, and there are no objective measures of the overall quality of care.); the plan's efficiency (How is this to be measured?); the "relative risk" for members of the plan as opposed to members of other plans (The relative risk of what? Being sick? Having expenses?); the "actuarial value or other comparative measure" of the benefits provided (which assumes the government can calculate prospectively the amount of claims the plan will pay); and, of course, the catchall any "other factors deemed relevant by" the officials at HHS. (One can only cringe at the thought of the extraneous factors that may emerge from this broad grant of power.) HHS officials must report to Congress on this methodology by September 2011. This should be interesting.

Determining "Value." More specifically, HHS officials are also required to develop a system to "rate qualified health plans…on the basis of the relative quality and price." The exchanges must apply this methodology to "assign a rating" to each plan offered through the exchange.[21] Value, of course, is the Holy Grail of judging any product or service, and most elusively so in the case of health care. The notion, however, that a government agency can pronounce the relative value of plans—or develop a methodology for doing so—for every American buying insurance through an exchange is quixotic. Markets, offering choices of goods and services that people in the real world actually want, are better equipped to make these judgments, not only because peoples' individual circumstances and judgments vary, but also because there is no objective answer to what constitutes the "value" of a plan.

18. On August 17, the NAIC Executive Committee announced its proposal for MLR definitions. This "blanks proposal" stipulates that the following expenditures by insurers would not constitute expenditures for claims payments or quality improvement: cost containment, organization of provider networks, and marketing. Information technology costs would have to be allocated between quality improvement and other, non-qualifying activities. Prevention of fraud and abuse would be qualified only up to the amount of recoveries. The proposal thus disfavors successful prevention programs. Press release, "NAIC Approves Form for MLF Financial Reporting Requirements," NAIC, August 17, 2010, at *http://www.naic.org/Releases/2010_docs/naic_approves_mlr_reporting_form.htm* (August 29, 2010).
19. Sections 2718(b) and (d) of the Public Health Service Act.
20. Section 10329.
21. Section 1311(c)(3); (d)(4). Presumably, although PPACA does not address the relationship between these two provisions, the methodology for rating the value of plans in an exchange would be derived from the more general methodology for determining plan value.

Destroying Private Insurance

Through these various provisions, HHS officials can affect the viability of the private insurance market and the ability of insurers to participate in it. HHS can control insurers' premiums and their ability to earn a profit—without the due process necessary for insurers to demonstrate their costs, including a guaranteed rate of return on invested capital, constitutionally required for regulation of rates of public utilities.[22] If, as is likely, the Obama Administration invokes these powers, insurers would be at the mercy of decisions by the federal government without the protections provided for state rate review. Government control is likely to be heavily influenced by political opportunity rather than economic reality. The result would be fewer insurers, essentially operating as government contractors. Under the authority granted by PPACA, the Administration can effectively destroy private health insurance by preventing insurers from earning reasonable profits and making investment in the sector highly unattractive. The "public option," championed by the Left as a precursor to a single payer system, can simply and easily be introduced through the backdoor.

Federal Control of Health Care Delivery

PPACA gives HHS the power to control how health care is delivered through its control of health plans.[23] PPACA requires HHS to develop standards for the exchanges to use in certifying the plans that can participate.[24] It lists a number of areas that HHS must control through these standards.[25] HHS can use this authority to impose its view on how health care should be delivered.

Number of Providers. The certification criteria must at a minimum "ensure a sufficient choice of providers" by members of a plan. This raises the question of how many providers the plan must include, which types of specialties, and which restrictions it may impose before a member can consult a specialist. This requirement, again, is an aspirational goal without definition. Central planning by HHS cannot produce the "right" answer to what is a sufficient choice for millions of consumers. HHS is not able to decide for every American, for instance, how quickly he should be seen by a doctor and when he should be able to consult a specialist. Would the standard vary by type of provider? By geographic area? How would HHS factor in the availability of non-physician providers? How far should patients be required to travel to get to a hospital? What kind of hospital? The rulemaking will enable federal officials to impose their view on these matters.

This provision can obviously be used as a hook for providers and suppliers to argue for mandatory inclusion of their products and services in health plans, even if they would not be included in policies that people would buy if they could exercise their own choice. HHS will have to choose which specialties are specifically required to meet the choice requirements.

Quality Accreditation. The HHS criteria for certification of a health plan must also require, PPACA says, that a plan be "accredited" with respect to its performance on "clinical quality measures," such as the Healthcare Effectiveness Data and Information set (which is not defined) and patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey." The plan must also be accredited by entities selected by HHS with respect to its performance on "consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals,

22. The constitutional failings of federal rate review under PPACA are discussed in Richard A. Epstein, "Impermissible Ratemaking in Health-Insurance Reform: Why the Reid Bill is Unconstitutional," Social Science Research Network, December 18, 2009, at *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1527128* (August 18, 2010).
23. PPACA also contains a number of provisions that explicitly permit HHS to experiment with different payment and delivery models under Medicare. PPACA advocates assume that changes in delivery models introduced by Medicare will also apply to the private market, since Medicare accounts for 20 percent of total health care spending. If this does not occur, the Administration could impose those changes under the authorities discussed.
24. Section 1311(c), (e).
25. Section 1311(c).

network adequacy and access, and patient information programs."[26]

HHS will thus select and deputize specific organizations to review discrete parts of plans' operations and to score plans' performances. The factors that these organizations will review—quality and access and patient satisfaction—go to the heart of health care, but measuring them is difficult and necessarily subjective. HHS and its chosen organizations will develop and implement seemingly sophisticated and complex measures of health care that, in fact, cannot be objectively measured. The process will entail an enormous bureaucratic load as plans seek to comply with the different tests selected. Yet the value of this exercise is uncertain at best. Reviews by the organizations selected by HHS could be helpful to consumers, to use as they see fit, along with other information. But under PPACA these organizations become gatekeepers that determine which plans can and cannot be offered to the consumer.

Control of Marketing. The standards developed by HHS must require that a plan "meet marketing requirements." Those requirements are not spelled out, giving HHS free range. HHS could assert authority to regulate every aspect of marketing—content of promotional materials; which forms of distribution can be used, and for which enrollees; the languages that must be used; and the size of the type font.[27]

Subjective Judgments. If a plan meets HHS's requirements for certification, an exchange may—but is not required to—certify the plan for participation if it also finds that including the plan in the exchange is "in the interests" of people buying insurance through the exchange."[28] The exchanges' open-ended, subjective definition of the public interest is added to the subjective judgments required under the HHS criteria for plan participation.

Implementation of Buzzwords. PPACA lists a host of other requirements for plan operations. These represent various concepts that many health policy analysts have suggested over the years as ways to reform health care delivery. HHS will have to translate the aspirations attached to these buzzwords into functional reality. In doing so, it will control plan operations and health care delivery.

A plan must implement a strategy that rewards quality by increasing reimbursement for "improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model"; activities to "prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional"; the use of "best clinical practices, evidence based medicine, and health information technology"; "implementation of wellness and health promotion activities"; and activities to reduce "health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings."[29]

These requirements are to be implemented through "guidelines" issued by HHS. That is a tall order. HHS will have to specify, for instance, what a plan (or more precisely, participating hospitals) must do to have a "comprehensive program" for discharge and define what constitutes "post-discharge reinforcement by an appropriate health care professional." It could impose requirements, for instance, that a hospital send a health care professional to the patient's home, post-discharge, and that the plan cover the visit. Having started down this road, its

26. *Ibid.*
27. In another, and atypically specific, provision, PPACA also requires HHS to develop standards for a uniform explanation of coverage. This explanation cannot be longer than four pages, and must be in at least 12-point font. Section 2715 of the Public Health Service Act, added by Section 1001.
28. Section 1311(e).
29. Section 1311(g).

guidelines would also have to explain who must be sent—a nurse, an aide, or another professional—and how often. HHS will have a free-fire zone to define "cultural competency training." Will HHS also specify who receives it? Every provider? Only some? If so, which ones? HHS will have to explain what health information technology must be used by plans and for what purpose.

Information Demands. Exchanges are required to obtain information from plans seeking certification. This information will be provided to government agencies, state and federal, and be made publicly available. It will include data on claims payment policies and practices; financial disclosures; enrollment and disenrollment data; the number of claims that are denied; and its rating practices. This of course gives the Administration and the exchanges broad power to require any data from insurers. But lest anything possibly be missed, the Administration is given a blank check to demand more: The exchange must require the insurers to provide any "other information as determined appropriate by" HHS.[30]

Language Control. In perhaps the peak of aspirational law-making, PPACA blithely requires that the information be provided in plain language: language that "the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain writing." From whence will this rare skill emanate? From the federal government, of course. Working together, officials at HHS and the Department of Labor will "develop and issue guidance on best practices of plain language writing."[31]

Federal Long-Term Care Insurance

Although there is a growing private market for long-term care insurance that offers choices of benefit packages and premium levels, PPACA puts the government directly in this market. It introduces what is in fact a "public option" for long-term care insurance—the Community Living Assistance Services and Supports Act (CLASS Act).[32]

HHS will develop three plans. A new Advisory Council, consisting of individuals from the private sector, including representatives of those who need and those who provide long-term care services, will examine the three plans and recommend to HHS which plan "best balances price and benefits" and should be designated the CLASS Independence Benefit Plan (the long-term care insurance that the federal government will operate). While the events triggering payment under the insurance are spelled out in the statute (the inability to perform two activities of daily living or substantial cognitive impairment), HHS can set its own triggering event—based on any functional limitation "similar to" those set in the law.

HHS will determine the premiums to be charged. The premiums are supposed to ensure solvency of the plan over 75 years without taxpayer assistance. In reality, CLASS poses the major risk of an expensive taxpayer bailout. HHS may set premiums at too low a level to be self-funded over time because of technical errors or political temptation. HHS may keep premiums artificially low to attract members away from the competing private market. Indeed, HHS will be inclined to do so if for no other reason than to justify the program. What is the purpose of the federal insurance unless it can charge lower premiums than the private insurance that is already available?

If the result is that the premiums established by HHS are not sufficient to pay the promised benefits, the onus will be on the taxpayer to make up the shortfall and ensure coverage for people who will have paid premiums for years and relied on the availability of this insurance. HHS may drive the private long-term insurers out of the market and impose a new burden on taxpayers for the cost of doing so.

Conclusion: A Baleful Prospect

PPACA legislates lofty goals for the reform of the health care payment and delivery system. It gives the Administration broad authority to implement

30. Section 1311(e).

31. *Ibid.*

32. Section 3201 *et seq.* of the Public Health Service Act, added by Section 8002(a).

these goals. They are impossible to reach, but in the process of trying, the Administration will control the future of private health insurance and shape how health care is delivered.

The scaffolding for this control is set up by PPACA. The Administration has the authority to build the structure. In the hands of an Administration that is hostile to private insurance and believes in governmental control of private activity, the prospect is daunting. The Administration will create mountains of regulations that will govern these activities. Health care will be politicized and made more cumbersome. The flexibility of providers and patients will be greatly reduced and creativity suppressed. Individual choice will be subordinated to decisions made by central authority. The regulations issued by the government will be grist for private litigation against providers and insurers. PPACA sets in motion dynamics that will increase the cost of health care, reduce its flexibility, and ultimately prove anathema to the kind of health care that Americans want.

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