

THE AFFORDABLE CARE ACT: DOES IT IMPROVE HEALTH AND DOES IT LIVE UP TO HUMAN RIGHTS STANDARDS?

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Let me begin with an assumption that health is a human right. One can find a right to health in Article 25 of The Universal Declaration of Human Rights, which provides that “[e]veryone has the right to a standard of living adequate for . . . health . . . , including . . . medical care.”¹ This document is considered “a milestone document in the history of human rights”² because it is the first record whereby nations collectively recognized, in writing, that some rights were so fundamental to human flourishing that they were to be universally protected.³

I. Human Rights Principles in Action

More than half of the countries around the world have incorporated a right to health or health care into their constitutions.⁴ This is an important consideration. Unlike declarations, which remain unenforceable assertions of guiding principles and values, constitutional provisions may incorporate a right to health as a positive right, thereby imposing obligations enforceable in courts of

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¹ Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948), *available at* <http://www.un.org/en/documents/udhr/>.

² *Universal Declaration of Human Rights*, OFFICE OF THE HIGH COMMISSIONER OF HUMAN RIGHTS, <http://www.ohchr.org/en/udhr/pages/introduction.aspx> (last visited July 16, 2015).

³ *Id.* See also Mark Wheeler, *A Constitutional Right to Health Care*, UCLA NEWSROOM (July 18, 2013), <http://newsroom.ucla.edu/releases/a-constitutional-right-to-health-247449> (where all UN members recognized the right).

⁴ Wheeler, *supra* note 3.

law.⁵ Not all constitutions of sovereignties impose a positive right to health or health care; only those provisions that actually contain the term “right” can impose a positive right. Without that term, constitutional provisions only express socioeconomic objectives.⁶

Even if a nation’s constitution does couch some aspect of health as a right, governmental obligations depend on what specific right has been conferred. For example, seventy-three U.N. member countries guarantee a right to medical care services and twenty-seven member countries guarantee a right to public health. This means that of all U.N. member countries, only thirty-eight percent constitutionally guarantee a right to medical care services and only fourteen percent ensure a right to public health.⁷

The United States is one of eighty-six countries which have no constitutional right to health or health care.⁸ But that does not necessarily mean that they do not fulfill the objectives of the Declaration that presents health as a human right. The International Covenant on Economic, Social and Cultural Rights (ICESCR), which is an important part of what is considered the International Bill of Rights,⁹ qualifies the right to health as State recognition of the “highest attainable standard.”¹⁰ The Covenant called upon nation-states to focus on four items of particular importance. Of these, two

⁵ World Health Organization, Regional Office for South-East Asia, *The Right to Health in the Constitutions of Member States of the World Health Organization South-East Asia Region 2-3*, SEA-HHR-02 (2011), available at http://www.who.int/hhr/news/SEA-HHR_RtH_constitutions.pdf.

⁶ *Id.* at 4 (finding that six of the eleven South-East Asian countries that included health or health care in their constitutions imposed it as a right).

⁷ Wheeler, *supra* note 3.

⁸ *Id.*

⁹ Beth Simmons, *Civil Rights in International Law: Compliance with Aspects of the “International Bill of Rights,”* 16 IND. J. GLOBAL LEGAL STUD. 437, 438 (2009). The additional documents include the Universal Declaration of Human Rights, The International Covenant on Civil and Political Rights (ICCPR), and two additional treaties: the Optional Protocol to the ICCPR and the Optional Protocol to the ICESCR. *Human Rights Explained: Fact Sheet 5: The International Bill of Rights*, AUSTRALIAN HUMAN RIGHTS COMMISSION, <https://www.humanrights.gov.au/> (last visited Jan. 31, 2015).

¹⁰ International Covenant on Economic, Social and Cultural Rights art. 12, December 16, 1966, 993 U.N.T.S. 3.

bear on this essay's discussion points: the call to provide medical care to the sick and the call to ensure the healthy development of children.¹¹ Significantly, separating health as a whole from medical care indicates that the Covenant's concept of health is broader than one referring merely to medical attention. Additionally, listing healthy development of children first suggests that it is of primary importance to human flourishing. As such, encouraging healthy development in a broad sense could include ensuring the well-being of families who care for the child, and this concern could outrank the general call to provide medical care.

A 2009 U.N. index has identified forty-two nations as ranking very high in human development. The United States ranks thirteen on the list. Some may be surprised that it is not in first place in the rankings. But the rankings are close: the highest, Norway, received a grade of .971, but the United States was not far behind with a score of .956.¹² This suggests that the United States may already be fulfilling the objectives of providing the highest attainable standard, especially when considering this additional information: The U.S. per capita health care expenditure of \$7,300 in 2010¹³ represents almost eighteen percent of the country's Gross Domestic Product. No nation expends more.¹⁴ This spending is split between the public and private sectors, but the absolute amounts are staggering.

Twenty-four percent of the nation's budget goes toward the Affordable Care Act, Medicare,¹⁵ Medicaid,¹⁶ and CHIP (Children's

¹¹ *Id.*

¹² Ervin B. Podgorsak, *Access to Health Care: A Basic Human Right or Privilege?* Int'l Conference on Radiation Medicine, at 24, www.radmed.org/Access%20to%20Health%20Care.pdf (last visited July 28, 2015) (with reference to 2009 Human Development Index of the United Nations Development Programme).

¹³ *Id.* at 53.

¹⁴ See *Health Expenditure, Total (% of GDP)*, THE WORLD BANK <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> (last visited Oct. 13, 2014).

¹⁵ *What is Medicare?*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> (last visited July 18, 2015) ("Medicare is the federal health insurance program for people who are 65 or

Health Insurance Program),¹⁷ which serves needy children. Of the \$836 billion budgeted in 2014, almost two-thirds went toward Medicare,¹⁸ which serves the elderly and disabled; while a little more than one-third was spent on the much larger population of needy families and children.¹⁹

II. *The Affordable Care Act and Improving Health Through Cost-Shifting*

This seems to be an important problem with The Affordable Care Act (ACA).²⁰ Why wasn't it effective in fixing the disproportionate amount of money that went to a disproportionate few? Why did it not require equal care for everyone? Why did it not result in extending care to all needy single people?

older, certain younger people with disabilities, and people with End-Stage Renal Disease”).

¹⁶ Medicaid is health care coverage program, funded jointly by state and federal government, which provides coverage to certain individuals who are classified as low income, elderly or living with a disability. *Medicaid*, U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html> (last visited July 18, 2015).

¹⁷ Generally, “CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.” *The Children’s Health Insurance Program (CHIP)*, U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/> (last visited July 18, 2015).

¹⁸ Approximately \$511 billion was allocated to Medicare costs. *Policy Basics: Where Do Our Federal Dollars Go?*, Center on Budget and Policy Priorities, <http://www.cbpp.org/sites/default/files/atoms/files/4-14-08tax.pdf> (last updated March 11, 2015).

¹⁹ *Id.*

²⁰ Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), amended by Health Care Education and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

A. *Structural Obstacles to ACA Objectives*

One factor consists in the conceptual difference between the social service programs funded all or in part by the federal government. Medicare is primarily a type of insurance that is paid for over the lifetime of employment of its beneficiaries. Medicaid, on the other hand, is purely public welfare supported by tax dollars.²¹

The second factor in understanding the problem rests in something that the ACA attempted to fix, but could not because of our structure of government. While many nations include a right to health care in their constitutions, our Constitution relegates authority to the states to provide for the health of their citizens, among other protective services.²² This reservation of authority in individual states poses a major obstacle to the objectives of the ACA: Constitutional authority vesting power in individual states makes it impossible for the ACA to achieve its objectives on its own.

B. *Fending Off Constitutional Barriers to Medicaid Expansion*

What Congress may not do directly, however, it may accomplish indirectly by providing states incentives to cooperate.

²¹ Woody R. Clermont, *A Brief Introduction to Medicare and the Office of Medicare Hearings and Appeals*, 5 PITT. J. ENVTL. & PUB. HEALTH L. 103, 105 (2011). Typically, employees pay into the Medicare system through Federal Insurance Contributions Act (FICA) paycheck withdrawals and receive payment from Medicare when they retire or meet other eligibility criteria such as permanent disability. *Id.* at 105.

²² U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”) Health is not a power delegated to the federal government by the Constitution. Thus, matters related to health are traditionally regulated by individual states. Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation*, 46 U. RICH. L. REV. 781, 801 (2012). Likewise, the business of health insurance has been traditionally regulated by individual states. OFFICE OF HEALTH POLICY, U.S. DEP’T OF HEALTH & HUMAN SERVICES, *THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET* 3 (2008), <http://aspe.hhs.gov/health/reports/08/reginsure/report.pdf> (last visited Feb. 17, 2015).

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Medicaid provides a good illustration of such federal-state cooperation. In the exercise of its constitutionally enumerated spending power,²³ Congress established an incentive for states to implement a state-run medical assistance program. In exchange for receiving federal funds to supplement state-financed and administered Medicaid programs, states were required to implement Congressionally-established criteria.²⁴

Prior to the ACA, states were only required to cover pregnant women, children, needy families, and certain disabled or old individuals. States had flexibility in determining the poverty level triggering Medicaid benefits to citizens. All states voluntarily participated, and each state had flexibility in determining eligibility, provided they met minimal federal standards.²⁵ Federal poverty levels below thirty-seven percent for unemployed parents and below sixty-three percent for employed parents represented the states' average.²⁶ By exercising discretion, each state was traditionally able to "align the size of its Medicaid program with its fiscal ability to fund it."²⁷

Under the ACA, Congress sought to expand Medicaid eligibility by requiring states to distribute Medicaid benefits to all persons below the age of sixty-five whose incomes fell below 133% of the federal poverty level.²⁸ Congress attempted to induce state cooperation by promising to provide 100% of the funds for state-

²³ U.S. CONST. art. I, § 8 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general welfare of the United States....").

²⁴ See 42 U.S.C. § 1396a (2010) (mandating what a state must provide under its state Medicaid plan in order to receive federal funds) and 42 U.S.C. § 1396b (2010) (quantifying the federal funds distributed to states).

²⁵ Jean C. Sullivan & Rachel Gershon, *Improved Health at a Reduced Cost? Economic Perspectives on the Patient Protection and Affordable Care Act*, 40 AM. J.L. & MED. 237, 240-41 (2014).

²⁶ Nat'l Fed'n of Indep. Bus. v. Sebelius, 256 S.Ct. 2566, 2601 (2012).

²⁷ Sullivan & Gershon, *supra* note 25 at 240.

²⁸ *Nat'l Fed'n of Indep. Bus.*, 256 S.Ct. at 2601. Because of a standard five percent disregard, eligibility expressed as 133% of the federal poverty level (FPL) is, in fact, 138% of FPL. Sidney D. Watson, *Embracing Justice Roberts' "New Medicaid,"* 6 ST. LOUIS U. J. HEALTH L. & POL'Y 247, 257-58 (2013).

administered Medicaid programs through 2016 and gradually reducing disbursement to 90%.²⁹ At first glance, it would seem that states would not hesitate to accept this federal generosity. However, some states were concerned about additional strains on their budget, even with additional federal support.³⁰ The additional 3.8 million Medicaid beneficiaries drawn in by the expansion would manifest a huge impact on state budgets. Texas and Florida would have had the greatest increase in numbers – 948,000 and 669,000 respectively.³¹ These figures do not take into consideration state burdens of providing care to illegal immigrants who are not covered at all under the ACA.³² Some states were also worried “that the federal government may revoke its contribution in the future and leave the states in a precarious position.”³³ The incentive to adopt the federal template was further heightened by the ACA’s declaration that a refusal to opt in would result in the withdrawal of all Medicaid funds, including those previously bargained for.³⁴

²⁹ *Nat’l Fed’n of Indep. Bus.*, 256 S.Ct. at 2601, referencing 42 U.S.C. § 1396d(y)(1) (2010).

³⁰ Jennifer Evans & Stephen Angelette, *1115 Waivers and the Future of Medicaid*, ABA HEALTH ESOURCE, Jan. 2015, http://www.americanbar.org/publications/aba_health_esource/2014-2015/january/1115.html (last visited July 28, 2015).

³¹ Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid – An Update*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, Table 1 at 6 (Nov. 12, 2014) <http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update>. The states which had the fewest uninsured were also the states most likely to opt into the expansion. *Id.* Ten years ago, almost 36% of the nation’s population lived in Texas, Florida, and three other states. Yet those same five states supported almost 50% of the uninsured population. Lisa Dubay, Christina Moylan & Thomas R. Oliver, *Advancing Toward Universal Coverage: Are States Able to Take the Lead?* 7 J. HEALTH CARE L. & POL’Y 1, 18 (2004).

³² See 42 U.S.C. § 18001(d)(1) (where ACA coverage includes only citizens, nationals, and legal aliens).

³³ Evans & Angelette, *supra* note 30.

³⁴ *Nat’l Fed’n of Indep. Bus.*, 132 S.Ct. at 2603-04, referring to 42 U.S.C. § 1396c.

C. Mandatory Medicaid Expansion Ruled Unconstitutional

In *National Federation of Independent Business v. Sebelius*, the Supreme Court held that these terms expressed in the ACA, which proposed to remove state discretion in determining Medicaid eligibility, were an unconstitutional exercise of Congressional power under the Spending Clause.³⁵ The Court likened the usage of the spending power to the formation of a contract. Congress is constitutionally authorized to induce state cooperation as long as states have knowingly and voluntarily accepted the terms offered in exchange for federal dollars. This voluntary acceptance by states ensures state sovereignty, freedom from federal coercion, and prevents Congress from shielding itself from accountability for decisions it compels states to make.³⁶ Applying these principles to the ACA, the Court concluded that state acceptance of the terms could not be considered free and voluntary. Noncompliance would not result in merely a loss of a “relatively small percentage” of funds, but an amount exceeding twenty percent of a state’s entire budget. The Court characterized this term not an acceptable inducement, but a “gun to the head.”³⁷

The Court pointed out that the terms of the expansion did not simply modify Medicaid, which Congress had the freedom to do under prior agreement with States. Instead, the new terms represented “a shift in kind, not merely degree.”³⁸ Initially, Medicaid was designed to provide coverage to four particular categories of needy recipients: the blind, elderly, disabled, and needy families with dependent children.³⁹ These groups either could not be expected to be self-sufficient, because of their disability, or they needed coverage to assure the well-being of the children they were raising.⁴⁰ Expansion to all poor people, including those without disability or

³⁵ *Id.* at 2607.

³⁶ *Id.* at 2602.

³⁷ *Id.* at 2604.

³⁸ *Id.* at 2605.

³⁹ *Id.* at 2605-06.

⁴⁰ Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 15 (2002).

without the responsibility of raising children, represented a completely different philosophy about what should be done for the well-being of citizens.⁴¹

As a result of the Court's holding in *National Federation of Independent Business v. Sebelius*, states were permitted to opt into the ACA's proposal to expand coverage, but were not required to do so.⁴² In addition, Congress was constitutionally prohibited from penalizing states by withdrawing previously-negotiated Medicaid support to states that chose not to opt into the ACA expansion terms.⁴³

III. Meeting ACA Cost-Shifting Objectives

A. Waivers

Permitting, but not requiring states to expand coverage to a wider than minimal group was not contrary to prior Medicaid cooperation between states and the federal government. Statutory "waivers" had already enabled states to provide coverage to expanded groups, including single persons.⁴⁴ Waivers offered states

⁴¹ *Nat'l Fed'n of Indep. Bus.*, 132 S.Ct. at 2606 (Under ACA principles, Medicaid "is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health coverage.").

⁴² As of November 2014, 29 states and the District of Columbia are opting into ACA expansion. *A 50-State Look at Medicaid Expansion*, FAMILIES USA, <http://familiesusa.org/product/50-state-look-medicaid-expansion> (last updated Jan. 28, 2015).

⁴³ *Nat'l Fed'n of Indep. Bus.*, 132 S.Ct. at 2607.

⁴⁴ 42 U.S.C. § 1315(a); Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. REV. 705, 762-64 (2005) (where waivers allowed states to devise their own creative strategies, including expanded coverage); Dubay, Moylan & Oliver, *supra* note 31, at 25 (noting that the most common pre-ACA use of Section 1115 waivers, pursuant to 42 U.S.C. §1315, was to provide coverage for childless adults). Waivers pursuant to 42 U.S.C. § 1396n also enabled states to save money by permitting them to move away from the traditional fee-for-services Medicaid provider payment (required under, e.g., 42 U.S.C. § 1396a(bb)(2) & (3)). Under a federally-approved waiver, states could channel Medicaid beneficiaries into managed care

some flexibility in making best use of federal dollars in accord with their own finances. Depending upon its constituency, a state could leverage its resources through waivers into expanding coverage to groups beyond those required by federal statute.⁴⁵

B. MAGI Accounting

While finding forced Medicaid expansion unconstitutional, the Court, in *National Federation of Independent Business v. Sebelius*, left intact the ACA's adoption of an accounting method that determined eligibility based on a modified adjusted gross income calculation, termed MAGI. Under the ACA, all states, including non-expansion states, are now accountable to the statutory MAGI calculation for determining Medicaid eligibility.⁴⁶

The MAGI accounting system leaves less room for states to assess Medicaid distribution. In particular, the new method has two wrinkles that must be considered: an elimination of the asset test and the elimination of deductions previously available for families.⁴⁷ Both of these have an impact on poor families.

Prior to the adoption of the ACA, a majority of states determined Medicaid eligibility based on both income and assets.⁴⁸ Use of both tests provided assurance that the most needy received the most help. Under the new ACA accounting method, states are

organizations where patient choice was limited. 42 U.S.C. § 1396n(b); 42 U.S.C. §1396u-2(a)(1).

⁴⁵ Sullivan & Gershon, *supra* note 25, at 241.

⁴⁶ 42 U.S.C. § 1396a(e)(14)(A); CENTERS FOR MEDICARE & MEDICAID SERVICES, DEP'T OF HEALTH & HUMAN SERVICES, *MAGI: Medicaid and CHIP's New Eligibility Standards Q3* (Sept. 30, 2013), <http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf> (Last visited Feb. 20, 2015).

⁴⁷ Christine Sebastian, *A Closer Look: Simplifying Enrollment and Eligibility with Modified Adjusted Gross Income (MAGI)*, FAMILIES USA, 1, 2 (2011), http://familiesusa.org/sites/default/files/product_documents/MAGI-Simplifying-Enrollment.pdf.

⁴⁸ *Id.*

prevented from applying both tests. No state may continue to use the asset test to determine whether a state citizen is eligible to receive Medicaid.⁴⁹

This could work an unfairness under some circumstances. For example, two single, able-bodied adults who are currently unemployed are treated as equally eligible, even if one is living hand-to-mouth and the other has non-income assets, no matter how great.⁵⁰ By contrast, states would not be required to treat both as equally eligible if states were permitted to apply an asset test to distinguish between the two. For states with a disproportionate share of poor people, it would be helpful to be able to use an asset test in order to assure the fairest distribution of resources. Regardless of whether coverage of childless adults or families is at issue, an inability to use the assets test prevents states from exercising power to discern who among its most poor should receive the scarce resources.

In addition to eliminating the asset test, the MAGI accounting method also eliminated deductions previously applied before determining Medicaid eligibility. Most notably, working parents could deduct from their gross income the amount actually spent on childcare that was related to their work. The post-deduction income was then compared to the state's Medicaid eligibility level.⁵¹

Deductions from gross income for childcare expenses are still permitted in determining what taxes are owed. But under the ACA, those deductions are added back in under MAGI for purposes of determining Medicaid eligibility.⁵² Because those deductions may no longer be used in determining Medicaid eligibility under the ACA, many families will no longer be eligible for Medicaid, even though their income and their expenses are the same as they were before, and even though the state's financial eligibility standards have not

⁴⁹ 42 U.S.C. § 1396a(e)(14)(C).

⁵⁰ See Sidney D. Watson, *Embracing Justice Roberts' "New Medicaid,"* 6 ST. LOUIS U. J. HEALTH L. & POL'Y 247, 258 (2013).

⁵¹ CENTERS FOR MEDICARE & MEDICAID SERVICES *supra* note 46, at Q6.

⁵² See 42 U.S.C. § 1396a(e)(14)(B); Kaye A. Thomas, *Modified Gross Income*, FAIRMARK PRESS (Nov. 15, 2013), <http://fairmark.com/retirement/roth-accounts/contributions-to-roth-accounts/modified-adjusted-gross-income/>.

changed.⁵³

Instead of their former deductions of actual expenses, families will only have a standard five percent disregard.⁵⁴ This is the same income disregard that also applies to the newly-eligible adults who do not have children or childcare expenses.⁵⁵ Without these important child care deductions, some families will be pushed out of Medicaid because their incomes will move onto the other side of the eligibility line. Moreover, as a result of this “equal” treatment across the board, families with children may end up in a worse position than single people with identical incomes.

Some applaud the new accounting method, noting that it results in administrative simplification.⁵⁶ Simplification has indeed been implemented. Unfortunately, it also provides an opportunity to “game” the system. More importantly, it can have a deleterious effect on some poor families who no longer qualify under the bright-line five-percent disregard rule.

For families who no longer qualify for Medicaid as a result of the mandatory imposition of MAGI accounting methods, the consequence may be grave. One might think that these families may not be in any worse position because, in place of Medicaid, they will

⁵³ See CENTERS FOR MEDICARE & MEDICAID SERVICES *supra* note 46, at Q4, Q9. In recognition of the consequences of the new accounting system, one expert suggests that those near the eligibility line because they could no longer deduct such assets as foreign-earned income and foreign housing invest in a 401k plan. See Thomas, *supra* note 52. How ironic that people rich enough to afford 401k plans can be eligible for Medicaid while parents may become ineligible simply because they may no longer deduct child-care expenses before determining eligibility for a health care system that was designed for the protection of children in their care.

⁵⁴ 42 C.F.R. 435.603(d)(1). This, in effect, changes eligibility from the expressed 133% of the federal poverty level to 138%. Watson, *supra* note 50, at 257-58.

⁵⁵ See, e.g., ILL. DEP'T OF HEALTHCARE & FAM. SERVICES, *Modified Adjusted Gross Income (MAGI) Budgeting for Medical, MAGI Income Standards and the 5% FPL Disregard* (Sept. 26, 2013), https://www.dhs.state.il.us/page.aspx?item=67265#a_toc16.

⁵⁶ E.g., Watson, *supra* note 50, at 258; Ann Marie Marciarille, *Let Fifty Flowers Bloom: Health Care Federalism After National Federation of Independent Business v. Sebelius*, 81 UMKC L. REV. 313, 322 (2012).

be insured under a marketplace plan and receive ACA insurance premium reimbursement. An analysis should shed light on some practicalities accompanying coverage under an exchange plan and receipt of premium tax credits.

C. Tax Credits

Poor families who are not eligible for Medicaid may purchase health insurance on a qualified exchange and receive tax credits.⁵⁷ Tax credits are available to those whose income is up to 400% above the poverty level.⁵⁸ Based on the 2015 poverty level, an individual whose income does not exceed \$47,080 would qualify for an ACA tax credit. A family of four would qualify if the aggregate family income did not exceed \$97,000.⁵⁹

But receiving a tax credit for paid premiums differs greatly from receipt of care under Medicaid. Unlike private insurance, there is little or no insurance premium to pay under Medicaid.⁶⁰ Medicaid offers more services than private insurance.⁶¹ In addition, the co-pay for Medicaid is much smaller.⁶² Therefore, post-payment receipt of

⁵⁷ 26 U.S.C. § 36B.

⁵⁸ 26 U.S.C. § 36B(b)(3)(A)(I) (amount of tax credit available based on a sliding scale of income compared to federal poverty level).

⁵⁹ HEALTHCARE.GOV, *Federal Poverty Level*, <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/> (last visited July 28, 2015). Calculations were based on the 2015 poverty level for individuals (\$11,770) and for families of four (\$24,250). *Id.*

⁶⁰ Robin Rudowitz & Laura Snyder, *Premiums and Cost-Sharing in Medicaid* KAISER COMMISSION ON MEDICAID & THE UNINSURED (Feb. 25, 2013), <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid/>. Forty states permit a Medicaid premium charge. Most premiums are for working disabled people under a “Ticket to Work” program. The program enables disabled people to stay in the system even though their income from work would otherwise be too high to retain Medicaid eligibility. *Id.* at 3.

⁶¹ John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 KY. L.J. 357, 361 (2014) (long term care, eyeglasses and dental services, for example).

⁶² See Sarah Kliff, *White House Proposes (Slightly) Higher Medicaid Co-Pays*, WASH. POST WONKBLOG (Jan. 14, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/14/white-house-proposes-slightly-higher->

tax credits does not put the poor in the same position they would be in if they qualified for Medicaid.

D. Tax Penalty

Let's turn to a limited examination of the practical effect of not receiving Medicaid benefits. Pursuant to the ACA, anyone over the Medicaid eligibility line must purchase health insurance from an exchange unless they receive health insurance under an employment plan or are statutorily exempt.⁶³ Those who fail to abide by ACA's mandate suffer a tax penalty.⁶⁴ These qualified health insurance plans must include ACA-determined "essential health benefits."⁶⁵ There are some variances permitted between plans, such as the types of drugs available on a particular plan's formulary, but all plans must include the requisite categories of care.⁶⁶ Plans are ranked in accord with premium cost. From lowest premium to highest, the plans are categorized as Bronze, Silver, Gold, or Platinum. The highest-priced insurance plans (Platinum level) secure the lowest out-of-pocket expenditures at the time of service, and vice versa.⁶⁷

The Bronze package is the least expensive plan. The 2014 national average for a Bronze plan for an individual was \$2,448 per year, or \$204 per month. For a family of five or more members, it was \$12,240 per year, or \$1,020 per month.⁶⁸ Someone who

medicaid-co-pays/ (where pre-ACA Medicaid co-pays averaged between \$1.30 and \$3.90 per service).

⁶³ 26 U.S.C. § 5000A(a), (d), and (e).

⁶⁴ 26 U.S.C. § 5000A(b).

⁶⁵ 42 U.S.C. § 18022(b).

⁶⁶ *Prescription Drug Costs and Health Reform: FAQ*, WEBMD (2013), <http://www.webmd.com/health-insurance/insurance-costs/aca-prescription-drug-costs-faq> (last visited Nov. 3, 2014); EMPLOYEE BENEFITS SECURITY ADMIN., U.S. DEP'T LAB., *FAQs about Affordable Care Act Implementation (Part XIX)* (May 2, 2014), <http://www.dol.gov/ebsa/faqs/faq-aca19.html>.

⁶⁷ 42 U.S.C. § 18022(d).

⁶⁸ IRS, *Individual Shared Responsibility Provision – Reporting and Calculating the Payment*, <http://www.irs.gov/uac/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment> (last visited Feb. 25, 2015).

purchases this plan will still have a very high co-pay and deductible. Therefore, purchasers will have additional expenses to the extent that they actually make use of the plan. Because of the high cost, some will decide not to purchase and instead pay the ACA tax penalty for non-purchase. Let's look at two examples.

In our first example, let's suppose that a family of five, consisting of two parents in their forties and three children younger than ten, earns \$400,000 solely from a foreign source. A tax return would be filed, but no taxes would be paid because the income came solely from a foreign source. Under ACA accounting, the income is added back before determining Medicaid eligibility.⁶⁹ Obviously, they would not qualify and would be required to purchase health insurance or pay the tax penalty. For a family of five, the 2014 Bronze plan was \$12,240 per year, but the penalty was only \$3,797.⁷⁰ The family – especially if relatively healthy – might decide to pay the penalty instead of the health insurance because they would save \$8,443. While the tax assessment is helpful to pay for expanded Medicaid coverage accepted by many states, it is problematic for cost-effective ACA operation unless enough healthy people opt in. Without sufficient numbers, insurance companies may have to spiral premiums upward to be able to spread the cost of paying for the sick.

For demonstration purposes, it is important to examine the effect of penalty increases scheduled to take place in 2015 and subsequent years. If we apply the same income, premium cost, and tax filing threshold, the family would owe \$7,594 in 2015 and \$9,492.50 in future years.⁷¹ While the incentive to be insurance-free

⁶⁹ 26 U.S.C. § 36B(d)(2)(B)(i); 26 U.S.C. § 911(a)(1).

⁷⁰ 26 U.S.C. § 5000A(c); IRS, *supra* note 68. The flat dollar amount would be \$295 because its calculation (300% of \$95) is less than the sum of the applicable dollar amounts (\$95)(2 adult parents) + (3 children)(½)(95) for 2014. But the actual amount owed is \$3,797 because its calculation (1%)(the excess of the tax return filing threshold of \$20,300, or \$400,000 - \$20,300) is greater than the amount owed under the flat dollar calculation. *See id.*

⁷¹ The formula for determining penalty remains the same, but the penalty amounts used in the calculations is substantially higher for flat rate and percent income calculations in 2015 and future years. *Id.* The flat rate shared responsibility per adult for 2015 is \$325. Allie Johnson, *Obamacare Penalty to Triple in 2015: How to Calculate Your Penalty*, (Oct. 27, 2014, 3:00:15 a.m.), INSURANCE

decreases significantly, a family who does not purchase mandatory health insurance still would enjoy a savings of \$4,646 in 2015 and \$2,747.50 in future years. If the family is relatively healthy, they might reasonably decide not to purchase health insurance. Or, if their primary expense is for medicine not on any formulary, the savings could be applied toward paying for those prescriptions. In the latter case, there would be no advantage to be insured because drugs not on plan formularies are typically paid for entirely by the insured, and those out-of-pocket expenses may not count toward meeting the ACA's statutory cap on personal health care expenditure.⁷²

In our second example, let's look at a married couple with two children and a much lower income of \$70,000. In 2014 the Bronze plan cost \$9,792, but the penalty was only \$497, or \$41.41 per uninsured month.⁷³ Using 2014 figures, except for the penalty amounts, the calculations reveal a penalty of \$995 in 2015 and \$2,085 in future years. If this family chose not to purchase insurance, the savings would be over \$7,500 in the year with the highest penalty for non-purchase. Of course, tax credits would also figure into a family's decision about whether to purchase insurance or pay the penalty.

Since the family earns about 290% above the 2015 poverty level for a family of four,⁷⁴ the family would be eligible for tax credits that would require them to pay a net amount of no more than approximately \$6,510, regardless of the actual premium cost.⁷⁵ The remainder would be paid for by the federal government in the form of a tax credit. Thus, even with a tax credit, the family would pay about \$4,500 more if they purchased health insurance than if they did not. A healthy family, or one whose primary expenses were not

QUOTES, <http://www.insurancequotes.com/health/obamacare-penalty-calculator>.

⁷² *Prescription Drug Costs and Health Reform: FAQ*, *supra* note 66; EMPLOYEE BENEFITS SECURITY ADMIN., *supra* note 66.

⁷³ IRS, *supra* note 68.

⁷⁴ HEALTHCARE.GOV, *supra* note 59 (where 2015 poverty level for families of four is \$24,250).

⁷⁵ 26 U.S.C. 36B(b)(2). Applying the sliding scale to that applicable percentage, the family would not be required to pay more than about \$6,510, which approximates 9.3 % of their income. *Id.* at (b)(3)(A).

covered under a plan, might reasonably decide to forego health insurance.⁷⁶

By requiring specific “essential benefits” packages rather than free market provisions of insurance packages tailored to varying needs, the ACA thereby encourages many healthy people to opt out of insurance. This seems contrary to the ACA objectives of providing affordable health insurance for everyone.

A family who does decide to purchase health insurance will incur expenses in addition to their net premium expenditure after tax credits. In particular, those who receive care will also be subject to out-of-pocket expenses, which “discourages the use of health services.”⁷⁷ The ACA terms these “deductibles, coinsurance, copayments, or similar charges” as “cost-sharing.”⁷⁸

Those who are at the eligibility borderline are unlikely to afford more than the minimal level of coverage provided by the ACA. In addition to paying Bronze level premiums (assumably reimbursed), the “cost-sharing” that requires payment from the “covered” may be so high that medical care previously sought under pre-ACA Medicaid will be forgone, potentially leaving them less healthy. This is because the Bronze level need only provide insurance coverage equivalent to sixty percent of the benefits received.⁷⁹ That still leaves a hefty amount that must be paid by the individual or somehow “written off.”

Even if a family opts to purchase the highest level subject to reimbursement by the federal government, the Silver level,⁸⁰ coverage only increases to seventy percent of benefits received.⁸¹

⁷⁶ One source estimated that between three and six million households could incur penalties for not securing health insurance in 2014. HHS and Treasury estimates were two to four percent of taxpayers. Tony Pugh, *Millions Might Face Tax Penalties Under Health Law*, MIAMI HERALD, Jan. 29, 2015, at C1.

⁷⁷ David Blumenthal, Kristof Stremikis & David Cutler, *Health Care Spending – A Giant Slain or Sleeping?* 369 N. ENGLAND J. MED. 2551, 2553 (2013).

⁷⁸ 42 U.S.C. § 18022(c)(3).

⁷⁹ 42 U.S.C. § 18022(d)(1)(A).

⁸⁰ 26 U.S.C. § 36B(b)(2).

⁸¹ 42 U.S.C. § 18022(d)(1)(B).

Thus, families who previously qualified for Medicaid but who are no longer eligible because the ACA-imposed accounting system has pushed them above the line shoulder a much greater burden as a result of the new rules.

The increased burden indicates that the ACA has taken a step backward in safeguarding health for some of those it sought to protect. Some needy families will not be eligible; and many will choose not to be insured. The ACA's objectives will not be advanced; and some will be less healthy – even with insurance.

IV. Effect on Access

A. Lowering and Restructuring Provider Fees

For those who do seek medical treatment under the ACA, there is some concern about whether they will have access to high quality care. One of the contributing factors is the lowering of fees paid to physicians who contract with the government or with marketplace plans to provide healthcare.⁸² Physicians who enter these contracts do not have control over the contractual fee schedules

⁸² Caleb Clarke, *How the Affordable Care Act Will Affect Provider Reimbursement*, NUEMD BLOG (Jul. 18, 2014), <http://www.nuemd.com/blog/affordable-care-act-will-affect-provider-reimbursement>; Robert Pear, *As Medicaid Rolls Swell, Cuts in Payments to Doctors Threaten Access to Care*, N.Y. TIMES, Dec. 28, 2014, at A20, available at <http://www.nytimes.com/2014/12/28/us/obamacare-medicare-fee-increases-expiring.html>. Following temporary increases in Medicaid provider payment, which some believe were offered as inducement to opt into the Medicaid system, fees for primary care will be cut by 43% or more. *Id.* See also, Jason Millman, *Obamacare Paradox: Medicaid is Expanding, but Doctors are Facing a Huge Pay Cut*, Dec. 10, 2014, <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/2010/>. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS & PROBLEMS 423-34 (7th ed. 2013) (Medicare); Brittany La Couture, *Health Care Providers are Opting-Out of Obamacare Exchange Plans*, AM. ACTION FORUM (Oct. 27, 2014), <http://americanactionforum.org/insights/health-care-providers-are-opting-out-of-obamacare-exchang-plans>. For every dollar paid by a private plan, a government plan would pay eighty cents and an exchange plan would pay sixty cents. *Id.*

because they work independently or in small groups. This arrangement prevents their having any real negotiating power. Lowering fees is thereby an easy way to keep the cost of providing healthcare services low.⁸³ However, it appears to have the undesirable effect on reducing access to service.

Any expectations that physicians would take on more ACA-covered patients to recoup their losses from reduced fees are not being met. Due to a provider shortage, physicians are already overburdened with their pre-ACA patient load. Unable to take on more work, the lower fees are simply “unsustainable.”⁸⁴ As a consequence, many physicians have chosen not to increase their Medicaid practices or to contract with exchange plans. And many physicians who were already in the system have chosen to opt out of some of the plans’ networks.⁸⁵

This has created problems for patients. As providers opt out of networks, there are fewer accessible doctors because they are not on the network provider’s list. Patients are left with narrow provider networks and little choice.⁸⁶ Compounding the problem is

⁸³ David W. Hilgers & Sidney S. Welch, *Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet*, HEALTH LAW., Feb. 2012, at 1, 3.

⁸⁴ La Couture, *supra* note 82.

⁸⁵ See e.g., *id.* (Medicaid & market plans); Jason Millman, *Obamacare Paradox: Medicaid is Expanding, but Doctors are Facing a Huge Pay Cut*, Dec. 10, 2014, <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/10/10/furrow-et-al.-supra-note-82-medicare/>.

⁸⁶ Scott Gottlieb, *No, You Can’t Keep Your Drugs Either Under Obamacare*, FORBES (Dec. 9, 2013, 7:22 a.m.), <http://onforb.es/1f1nACT> (last visited Nov. 3, 2014). To save costs, almost half of all exchange plans are comprised of narrow provider networks. That means that there are very few providers from which to choose. Provider choice is even more severely limited if an insured’s current provider is not already on the list. For example, one federal exchange insurance consumer discovered (after signing up) that there were only ten primary care physicians in the network, eight of which were unavailable to him because they were not taking new patients. Avoiding this type of disappointment is not easy. According to Sabrina Corlette, who is a senior research fellow at Georgetown University’s Center on Health Insurance Reform: “Even when they did their homework, it is very difficult to understand what network you were buying into.” Chabeli Herrera, *Some Obamacare Consumers are Lacking Options*, MIAMI HERALD, Feb. 15, 2015, at B1-2.

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information inaccessibility. Patients either have no lists or confusing lists, which make it difficult for them to figure out whether they can continue care with their current provider.⁸⁷ Expectations have been frustrated when patients discover that physicians they used under their former non-exchange plan are not part of their exchange plan's provider network, even though their insurance company remained the same.⁸⁸

Physicians who do participate in governmental or exchange plans are financially induced to integrate care under an HMO-type model or to capitate payment.⁸⁹ Under a capitated payment schedule,

⁸⁷ La Couture, *supra* note 82.

⁸⁸ Kelli Kennedy, *Consumers Losing Their Doctors With New Plans*, MIAMI HERALD, May 15, 2014, at A1.

⁸⁹ See generally FURROW ET AL., *supra* note 82. In the traditional fee-for-services model, Medicare providers receive payment in accord with the scheduled fee for the service provided. CENTERS FOR MEDICARE & MEDICAID SERVICES, DEP'T OF HEALTH & HUMAN SERVICES, *Fee Schedules – General Information*, <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/> (last visited Feb. 7, 2015). Under the ACA, the fee-for-services payment option remains, but providers can instead opt to be paid a monthly fee to work with other providers for integrated care in Accountable Care Organizations (ACOs). An incentive for providers to move into an ACO model is that those who meet certain standards share in savings to Medicare. CENTERS FOR MEDICARE & MEDICAID SERVICES, DEP'T OF HEALTH & HUMAN SERVICES, *The Affordable Care Act: Helping Providers Help Patients*, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/downloads/ACO-Menu-Of-Options.pdf> (last visited Feb. 7, 2015). The ACO framework is very similar to the capitated managed care framework of the 1990s. In both, providers receive set fees and keep what has not been spent on patients. The idea is that providers will not do unnecessary testing that drives up costs. Some believe this move to be an untested theory that was not previously successful – the earlier model did not garner sufficient trust to be statistically relevant. Steffie Woolhandler & David Himmelstein, *SinglePayer FAQ: What is PNHP view of ACOs?*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.pnhp.org/facts/single-payer-faq#response-papers> (Last visited February 17, 2015). Others view this move as catching up with what states were already doing in their move from fee-for-services to Medicaid managed care (MMC). In the early 1990s, as suggested by Woolhandler and Himmelstein, the program had few enrollees – only 12%. However, over time, enrollment in MMCs grew to 74%. Nicholas W. D'Aquila & Emma J. Chapman, *Upcoming Medicaid Managed Care Proposed Rule: What to Expect*, ESOURCE, Jan. 2015, http://www.americanbar.org/publications/aba_health_esource/2014-2015/January/ (last visited Jan. 29, 2015).

providers are paid per patient rather than per service. Capitation under a managed care model has the potential to create incentives for providers to limit access to diagnostic and other services.⁹⁰

Along with this restructuring is a move to make up physician shortage with increased dependence on nurse practitioners and physician assistants as primary care designees instead of physicians.⁹¹ The consequence of this movement may be to decrease, rather than increase, access to quality provider care.⁹²

B. Non-Generic Drug Availability

Access to drugs may also be limited. One of the mechanisms funding the new insurance structure is the skimpiness of paying for costlier branded drugs,⁹³ which are often not included on a plan's formulary. If a drug is not on the formulary, then it is not included on the co-pay list. This means that a patient may have to pay the full cost of the medicine and, in addition, may not be able to count payment for the pharmaceutical against their deductibles.⁹⁴

⁹⁰ D'Aquila & Chapman, *supra* note 89.

⁹¹ U.S. Dep't Health & Human Services, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*, HRSA HEALTH WORKFORCE (Nov. 2013), <http://bhpr.gov/healthworkforce/supplydemand/usworkforce/primarycare/>. Twenty-one states explicitly authorize nurse practitioners to be Medicaid primary care providers in place of physicians. More expansive use of nurse practitioners as primary care leaders is expected. Maria Schiff, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*, NGA CENTER FOR BEST PRACTICES 1, 3, 13 (Dec. 2012), <http://nga.org/cms/sites/NGA/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>.

⁹² D'Aquila & Chapman, *supra* note 89; La Couture, *supra* note 82.

⁹³ Gottlieb, *supra* note 86. See also John Connolly, *The Affordable Care Act: How Is It Financed?* INSURE THE UNINSURED PROJECT (Sept. 26, 2012), <http://itup.org/health-financing/2012/09/26/the-affordable-care-act-how-is-it-financed/> (where ACA-imposed fees will be charged for brand-name pharmaceuticals to help fund Medicare). The ACA will also recoup some expenses by charging a 2.3% excise tax on any FDA-approved medical device except for traditional Medicaid-supplied devices such as eyeglasses, contact lenses, hearing aids, and those devices readily available at retail stores. 26 U.S.C. § 4191.

⁹⁴ Gottlieb, *supra* note 86.

Therefore, it will not be included in the ACA-required out-of-pocket max.

Some see not including certain medicines or placing brand-name and other specialty drugs on a plan's costliest drug tiers as a means of getting around the ACA's denial-of-coverage or pre-existing condition prohibitions. Placing medicine out of financial reach for those who need them discourages high-cost patients from enrolling in those plans. Evidence of adverse tiering was found with respect to HIV drugs and medicines for other high-ticket conditions such as "mental illness, cancer, diabetes, and rheumatoid arthritis."⁹⁵

Tiering drugs not only channels beneficiaries away from certain plans, it also channels them into using lower-cost generic or preferred drugs. The least expensive, generic drugs, are included on the lowest tier.⁹⁶ The second tier includes preferred brand-name medicines. The items constituting this tier are determined by contractual negotiations with pharmaceutical manufacturers or suppliers to supply them at a low cost. The third tier includes non-preferred brand-name medicines. At the highest tier are the specialty medicines such as HIV drugs, which, because of the expense, can induce adverse selection by users.⁹⁷

⁹⁵ Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace*, 372 N. ENGLAND J. MED. 399, 401 (2015); Nicholas Nehamas, *Obamacare May Mean High HIV Drug Costs*, MIAMI HERALD, Oct. 27, 2014, at A1 4.

⁹⁶ Generics are less pricey because it is much less expensive to bring them to market. While manufacturers might have to expend over \$1 billion for research and development of new (branded) drugs, they might only spend a million or two to bring a generic drug to market. *ASPE Issue Brief: Expanding the Use of Generic Drugs*, DEPT. OF HEALTH & HUMAN SERVICES, 1, 7-9 (Dec. 1, 2010), <http://aspe.hhs.gov/sp/reports/2010/genericdrugs/ib.pdf>. Generic manufacturers capitalize on branded manufacturers' work efforts because they can achieve "bioequivalence" to the branded drugs simply by reverse engineering the manufacturer's formula. Ananya Mandal, *Generic Drug Cost*, NEWS MEDICAL, <http://www.news-medical.net/health/Generic-Drug-Cost.aspx> (last updated Sept. 10, 2014).

⁹⁷ Melinda Beck, *Drug-Cost Surprises Lurk Inside New Health Plans*, U.S. NEWS (Dec. 4, 2013) <http://www.wsj.com/articles/SB10001424052702303722104579238263770197936>; WEBMED MEDICAL REFERENCE, *Prescription Drug Costs and Health Reform: FAQ*, <http://www.webmed.com/health-insurance/>

Encouraging beneficiaries to use lower cost generic drugs is not a new ACA phenomenon.⁹⁸ But it will aggravate problems already faced by some patients who experience difficulty with generic drugs. While brand-name and generic drugs contain identical active ingredients, their inactive ingredients differ. These differences may be significant. Dyes or binders constituting the inactive ingredients in a generic counterpart may cause allergic reactions that would not occur if a sensitive patient had used the brand-name drug.⁹⁹

There is some allowance for sensitive patients to obtain the costlier name-brand drugs. However, it is not simple to ensure. The process is complicated by a variety of state laws, some of which require pharmacists to make a “therapeutic substitution” to a generic drug unless a physician uses the state-determined “magic words” that specify that brand name drugs are medically necessary.¹⁰⁰

If a physician does not use the triggering language on the prescription in a state that requires a very specific indication, a patient will not receive the brand-name drug even if it is necessary because of an allergy to the generic ingredients. If the patient refuses the generic name drug, the patient is out-of-pocket for the entire cost or for the price difference between the brand-name and the generic. Moreover, the extra amount paid for the brand-name drug may be partially or completely excluded from counting toward the out-of-pocket annual limit on cost-sharing.¹⁰¹

The aggressive push toward generic drugs certainly leads to a problem of cost for those who need them. It also will result in

insurance-costs/aca-prescription-drug-costs-faq (last reviewed on May 4, 2013).

⁹⁸ Jacobs & Sommers, *supra* note 95, at 400.

⁹⁹ *ASPE Issue Brief*, *supra* note 96, at 12. The inactive ingredients can be of lower quality, and may affect the active ingredient’s dissolution and absorption into the bloodstream. Katherine Eban, *Are Generics Really the Same as Branded Drugs?* FORTUNE.COM, (Jan. 10, 2013), <http://fortune.com/2013/01/10/are-generics-really-the-same-as-branded-drugs/> (discussing FDA’s withdrawal of approval for the Wellbutrin generic version manufactured by Teva).

¹⁰⁰ *ASPE Issue Brief*, *supra* note 96, at 7 (where Appendix A lists by state what physicians must indicate on a prescription to ensure brand-name products are delivered to patients).

¹⁰¹ EMPLOYEE BENEFITS SECURITY ADMIN., *supra* note 66, at Q3.

shortages of brand-name drugs as soon as patents run out, or sometimes before.¹⁰² Currently, when there is a generic equivalent, the generic is dispensed almost ninety percent of the time.¹⁰³ The ACA will likely contribute to the shrinking availability of name brand drugs since brand-name prescription manufacturers will be assessed an aggregate fee of between \$2.5 billion and \$4.1 billion every year.¹⁰⁴ While channeling providers to prescribe, and patients to use, generic drugs may be very cost effective, it can have a negative impact on health or affordability for some population groups.

C. *Potential Impact on Poor Hospitals*

Financial incentives meant to promote quality and efficiency may also have a negative impact on hospital care. Under ACA Hospital Value-Based Purchasing, a certain amount of anticipated governmental payment is withheld for later distribution to hospitals with the highest performance on specific quality measurements. Hospitals serving the least affluent population group can be severely disadvantaged in receiving the high performance distributions under its current formulation. Already tending to be the lowest performers, these hospitals would have to exhibit a proportionately higher improvement in performance than hospitals already topping the list in order to receive any funding from the “withhold” pool. Because these hospitals are likely to be ineligible to receive the very funds that could be applied toward quality-improvement initiatives, the mechanism meant to improve healthcare could, in effect, “expand the quality gap in the care provided to more affluent and less affluent patients.”¹⁰⁵

¹⁰² *ASPE Issue Brief, supra* note 96. The Hatch-Waxman Act increased generic availability by providing an abbreviated approval pathway for generic drug manufacturers, incentives for challenging patents, and creating exemptions for some patent infringement. *Id.* at 9.

¹⁰³ *Id.* at 3-4.

¹⁰⁴ Connolly, *supra* note 93.

¹⁰⁵ Andrew M. Ryan, *Will Value-Based Purchasing Increase Disparities in*

V. *ACA-Mandated Female Preventive Care and Spiritual Health*

There are other problems associated with the Affordable Care Act, but the most significant is its interference with spiritual health. This defect in the ACA is most apparent in the context of what must be included (and paid for) as covered care.

The ACA requires qualified health plans to offer a list of essential benefits.¹⁰⁶ Included are “preventive care and screenings” for women without “any cost sharing requirements.”¹⁰⁷ Details about what to include were left to the Health Resources and Services Administration of the Department of Health and Human Services.¹⁰⁸ Pursuant to the agency’s regulations, many valuable preventive services such as mammograms and prenatal care incur no cost-sharing expenses. The regulations also provide that, absent exemption, no cost sharing accrues for any FDA-approved “contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.”¹⁰⁹ This latter provision warrants exploration.

A. *Potential Interference with Parental Rights*

First of all, parental involvement in vital matters concerning their minor children potentially could be bypassed. Female reproductive capacity is often reached in pre-teen or early teen years. Since defined treatment and counseling is mandated for them at no cost, and physician-patient confidentiality exists, children will not necessarily have to confer with, notify, or permit parents to have any input in this important aspect of their lives.¹¹⁰ This could intrude on

Care? 369 N. ENGLAND J. MED. 2472, 2472 (2013).

¹⁰⁶ 42 U.S.C. § 18022(b)

¹⁰⁷ 42 U.S.C. § 300gg-13(a).

¹⁰⁸ 42 U.S.C. § 300gg-13(a)(4).

¹⁰⁹ HEALTH RESOURCES & SERVICES ADM., U.S. DEP’T HEALTH & HUMAN SERVICES, *Women’s Preventive Services Guidelines* (August 1, 2011), <http://www.hrsa.gov/womensguidelines/>; 45 C.F.R. § 147.130(a)(1).

¹¹⁰ See Letter from U.S. Conf. Cath. Bishops to Centers for Medicare &

families and interfere with parental rights to bring up their minor children and make medical decisions on their behalf.¹¹¹ And here, its significance extends to moral and religious upbringing.

B. Moral Considerations

It is widely recognized that adherents to Judeo-Christian religions have moral problems with some of the ACA-included practices. For example, Roman Catholics believe that artificial contraception and voluntary sterilizations as a whole are immoral.¹¹² Performing voluntary sterilization is considered contrary to human dignity because it is deemed not good for patients. This stems from the fact that instead of improving health, it “renders inoperable an otherwise healthy system of the body.”¹¹³

Other religions may not have a problem with voluntary

Medicaid Services, Re: Advance Notice of Proposed Rulemaking 7 (May 15, 2012), available at <http://www.usccb.org.nnhj> [hereinafter Letter of U.S. Conf. Cath. Bishops].

¹¹¹ Unlike with respect to abortion, where parental bypass may be more justifiable, parental counseling about “preventive” behavior has no such urgency that would demand their having no input.

¹¹² Jozef Laurinec, *Ethical Problems in the Use of Hormonal Contraception*, 14 NAT’L CATH. BIOETHICS Q. 491, 495 (2014). Artificial contraception separates the unitive and procreative meaning of the conjugal act, which “injures the truth of the human person.” Paul F. DeLadurantaye, *Contraception and the Person: Speaking at Cross-Purposes*, 3 NAT’L CATH. BIOETHICS Q. 33, 35 (2003). Contraception impedes the “actualization of the language of the body in its integral truth” and transforms intercourse into an act that uses another person as an object. *Id.* This objectification of the other is contrary to human dignity, which requires treatment of another person as an end. *Id.* at 37-38. Catholics recognize the good of spacing children, but see natural family planning as removing a double-standard between male and female. Although artificial birth control purports to free women, to the extent that it does, it is at the expense of the woman’s bodily integrity. By contrast, natural family planning is a joint method requiring both partners to exercise of self-mastery. Mary Shivanandan, *Natural Family Planning and the Theology of the Body*, 3 NAT’L CATH. BIOETHICS Q. 23, 29, 30 (2003).

¹¹³ John M. Haas, *There Are No “Prohibited Services,”* ETHICS & MEDICS, Mar. 2010, at 1. Voluntary sterilization violates the principle of totality and integrity of the human body. Steven P. Rohlf, *Sterilization: The Catholic Teaching*, ETHICS & MEDICS, June 1998.

sterilization or contraception per se, but do object to the forced coverage of IUDs, Plan B, and ella, which were specifically included on the list.¹¹⁴ The objection arises from their operational function.¹¹⁵ Unlike true contraceptives that prevent the union of egg and sperm, these methods also cause changes in the uterine lining that interfere with implantation of an already formed embryo. Embryonic survival is thus made impossible.¹¹⁶ For that reason, these methods operate as abortifacients. Therefore, providing or facilitating use of those methods is problematic because it violates the moral ethics of many.

C. *Presentation to Consumers*

The problem is compounded by the way that these ACA benefits are presented to consumers. HealthCare.gov reaches out to consumers and provides a list of covered contraceptive methods: barrier methods, hormonal methods, female sterilization, IUDs, and emergency contraception like Plan B and ella. It goes on to say that “drugs to induce abortions” are not part of the list of required coverage.¹¹⁷ From the website’s presentation, a woman could reasonably believe that all of the listed methods merely prevent the union of egg and sperm. How does that promote informed choice, which is critical in a matter so fundamental to human flourishing?¹¹⁸

Savvy women might recognize that they cannot trust

¹¹⁴ HEALTHCARE.GOV, *What Plans Cover*, <https://www.healthcare.gov/coverage/birth-control-benefits/> (last visited Nov. 3, 2014).

¹¹⁵ Frederick Mark Gedicks & Rebecca G. Van Tassell, *RFRA Exemptions from the Contraception Mandate: An Unconstitutional Accommodation of Religion*, 49 HARV. C.R.-C.L. REV. 343, 353 (2014).

¹¹⁶ June Mary Z. Makdisi, *Genetically Correct: The Political Use of Reproductive Terminology*, 32 PEPPERDINE L. REV. 1, 20-22 (2004). IUDs may also be abortifacient because they prevent the uterine lining from growing thick enough to sustain a healthy pregnancy. WEBMD, *Intrauterine Device (IUD) for Birth Control* (May 7, 2013), <http://www.webmd.com/sex/birth-control/intrauterine-device-iud-for-birth-control>.

¹¹⁷ HEALTHCARE.GOV, *supra* note 114.

¹¹⁸ See *Roe v. Wade* 410 U.S. 113 (1973) (fundamental right to privacy in matters of reproductive choice).

governmental reassurance about what is contraception and what is abortion. These women have an opportunity to avoid moral wrongdoing by educating themselves about the operative functions of the methods they are considering. But many employers who have moral objections are not provided that luxury. Unless statutorily exempted, their choices are limited. They must either provide ACA-approved plans (with the objectionable coverage), or refuse to provide health insurance to employees. If they choose the latter, they will suffer the statutory penalty as a consequence of their decision.¹¹⁹

D. Imposition on Employers

Many commentators do not see the dilemma facing these employers because of their focus on the women. After all, it is women who have the ultimate choice about whether to take contraceptive or abortifacient action to prevent birth. These commentators see objectors as interfering with women's rights, and plans as merely facilitating choices in the exercise of those rights.¹²⁰ But, of course, therein lies the problem – the *facilitation* of a “morally objectionable” act.¹²¹

¹¹⁹ 26 U.S.C. § 4980H. Non-compliant employers with more than 50 employees will be assessed \$2,000 per employee, but will not pay fines on the first 30 employees. David M. Dirr, *The Other Exchanges: Private Exchanges and Healthcare Reform*, HEALTH LAW., Dec. 2013, at 46, 48.

¹²⁰ See, e.g., Colleen Connell et al., *Religious Refusals Under the Affordable Care Act: Contraception as Essential Health Care*, 15 DEPAUL J. HEALTH CARE L. 1, 13 (2013); W. David Koeninger, *Removing Access to Health Care From Employer and State Control: The ACA as Anti-Subordination Legislation*, 44 U. BALT. L. REV. 201, 219 (2015); Gedicks & Van Tassell, *supra* note 115, at 383-84; Susan Berke Fogel, *Health Care Refusals and the ACA: What's Next?*, HEALTH ADVOCATE, (Jul. 1, 2012), <http://www.healthlaw.org/issues/>.

¹²¹ Press Release, U.S. Conf. Cath. Bishops, USCCB Submits Comments on Proposed HHS Rulemaking, Urges Re-Opening of Final Rule Defining Mandate, Exemption (May 15, 2012), *available at* <http://www.usccb.org/news/2012/12-048.cfm> (where premiums and plans recognized as “conduits” for objectionable services).

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E. Facilitation of an Immoral Act

Employers who must offer to provide coverage under any plans are forced to cooperate in acts they view as immoral, even though they themselves are not the actors who perform the objectionable acts. From an ethical perspective, employers who choose to offer the objectionable coverage rather than to opt out and pay the penalty could be viewed as providing “material cooperation” to the acts themselves.¹²² The Supreme Court identified this forced cooperation as a problem with the ACA in its *Hobby Lobby* decision.¹²³ The quandary is particularly problematic for employers whose institutions are anchored on moral beliefs that acknowledge the sanctity of human life at all stages of human development and recognize the moral importance of accepting a gift of life that results from voluntary intercourse.

F. Exemptions and Accommodations

The regulations authorized by the ACA did render a narrow exemption for “group health plans sponsored by religious

¹²² See D. BRIAN SCARNECCHIA, *BIOETHICS, LAW, AND HUMAN LIFE ISSUES: A CATHOLIC PERSPECTIVE ON MARRIAGE, FAMILY, CONTRACEPTION, ABORTION, REPRODUCTIVE TECHNOLOGY, AND DEATH AND DYING* 86, 86 (2010). This was the basis for the claim in *Wheaton College v. Burwell*, 134, S.Ct. 2806, 2809 (2014) (Sotomayor, J., dissenting) (submission of form to third-party administrator to fulfill statutory mandate required objector to be “complicit” in objectionable act).

¹²³ *Burwell v. Hobby Lobby*, 134 S.Ct. 2751 (2014). It recognized the plaintiffs’ belief that

providing the coverage demanded by the HHS regulations is connected to the destruction of an embryo in a way that is sufficient to make it immoral for them to provide the coverage. This belief implicates a difficult and important question of religion and moral philosophy, namely, the circumstances under which it is wrong for a person to perform an act that is innocent in itself but that has the effect of enabling or facilitating the commission of an immoral act by another.

Id. at 2778. The Court maintained that imposing the required coverage was tantamount to wrongly “tell[ing] the plaintiffs that their beliefs are flawed.” *Id.*

employers.”¹²⁴ As originally defined by the agency, a religious employer qualifying for the exemption had to be a non-profit organization who primarily employed and served persons who shared its religious tenets, and whose purpose was to inculcate its religious values.¹²⁵ This exemption primarily applied to “churches and other houses of worship.”¹²⁶ Churches and their non-profit “integrated auxiliaries” were thereby exempt from providing contraceptive coverage, as long as an auxiliary’s primary financial support came from the church. This meant that self-supporting entities such as religiously-affiliated universities and hospitals would not qualify for an exemption.¹²⁷

President Obama then announced an accommodation to assure that there would be no “direct” provision of the contraceptive services by a religious institution.¹²⁸ The Department of Health and

¹²⁴ *Women’s Preventive Services Guidelines*, *supra* note 109; 45 C.F.R. § 147.130(a)(1).

¹²⁵ 45 C.F.R. § 147.130(a)(1)(iv)(B) (2011).

¹²⁶ CMS.GOV, THE CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, *Women’s Preventive Services Coverage and Non-Profit Religious Organizations* (Aug. 2014), available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/>. Section 6033 exemptions to which the religious employer exemption applied included “churches, their integrated auxiliaries, and conventions or associations of churches” (26 U.S.C. § 6033(a)(3)(A)(I)) and “the exclusively religious activities of any religious order.” 26 U.S.C. § 6033(a)(3)(A)(iii).

¹²⁷ IRS, “*Integrated Auxiliary of a Church*” Defined (Apr. 24, 2014), <http://www.irs.gov/Charities-&-Non-Profits/Churches-&-Religious-Organizations/>; Elizabeth Sepper, *Contraception and the Birth of Corporate Conscience*, 22 AM. U.J. GENDER SOC. POL’Y & L. 303, 307 (2014). Many mission-centered, church-affiliated entities would not be exempted. For example, if a retirement home were affiliated with a church and “governed entirely by the church’s principles and teachings,” it would not qualify for an exemption if it received less than half of its income from the church because it would not be primarily funded by “internal support.” Gail Finke, *How Exactly Will the HHS Mandate Kill Religious Freedom?* CATHOLIC EXCHANGE, June 8, 2013, at 3, available at <http://catholicexchange.com/how-exactly-will-the-hhs-mandate-kill-religious-freedom>.

¹²⁸ Press Release, Barack Obama, Remarks by the President on Preventive Care (Feb. 10, 2012), available at <http://www.whitehouse.gov/the-press-office/2012/02/10/>.

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Human Services (HHS) issued a temporary “safe harbor” on enforcing the contraceptive provisions against certain objecting groups¹²⁹ and proposed accommodations for religious objectors.¹³⁰

The United States Conference of Catholic Bishops (USCCB) concluded that the proposed accommodations were not meaningful even for those organizations that qualified for an exemption. The organizations were still required, through the self-certification process, to facilitate the provision of objectionable coverage. According to their analysis, religious organizations would ultimately pay for the objectionable services, and their plans would continue to function as funding sources or as “conduits” of objectionable services.¹³¹

The HHS then issued another ruling on June 28, 2013. It maintained its religious employer exemption and added a regulatory accommodation for additional non-profit religious entities who held themselves out as religious organizations and who opposed providing some or all of the mandated contraceptive services.¹³² With this addition, both religious employers and self-supporting religiously-affiliated institutions could avoid the ACA’s insufficient-coverage tax penalty by complying with the agency’s procedural requirements. Qualifying entities were to file the requisite notice to all the entity’s plan issuers or, in the case of self-insured organizations, to third-party administrators (TPAs). The notice authorized the issuers and TPAs to communicate with the beneficiaries, and to administer financial coverage for (objectionable) mandated services. In either

¹²⁹ Memorandum from the Center for Consumer Info. & Ins. Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans and Group Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under Section 2713 of the Public Health Service Act, Section 715(a)(1) of the Employee Retirement Income Security Act and Section 9815(a)(1) of the Internal Revenue Code (June 28, 2013), at 1 n.1, *available at* <https://www.cms.gov/> (initial safe harbor provision issued on Feb. 10, 2012).

¹³⁰ U.S. Conf. Cath. Bishops, *supra* note 110, at 1 (citing 77 Fed. Reg. 16501 (March 21, 2012)).

¹³¹ *Id.* at 10-14.

¹³² *Women’s Preventive Services Coverage and Non-Profit Religious Organizations*, *supra* note 126; 45 C.F.R. § 147.131(a) & (b) (2013).

case, employees would still receive free coverage.¹³³

The accommodation's effect was consistent with President Obama's assurance that no "direct" provision of service was required.¹³⁴ But the "indirect" provision, as outlined above, failed to shelter objecting employers from material cooperation. The Supreme Court ordered injunctive relief to Wheaton College on that basis.¹³⁵

Another defect pointed out by the USCCB was that regulatory focus on institution failed to safeguard the moral beliefs and practices of objecting individuals and for-profit businesses. It maintained that governmental protections should extend to all "the faithful in their daily lives."¹³⁶

G. *Unconstitutional Interference with Religious Beliefs*

This flaw was partially resolved in the consolidated cases of *Burwell v. Hobby Lobby* and *Conestoga Wood Specialties Corporation v. Burwell*.¹³⁷ The Court conceded that businesses were

¹³³ *Women's Preventive Services Coverage and Non-Profit Religious Organizations*, *supra* note 126; Brian Fraga, *Final HHS Mandate Rule Decried as 'More of the Same,'* OUR SUNDAY VISITOR, July 14, 2013, at 7. The TPA provision "gives the administrator the legal authority to provide the very coverage to which the organization objects." Richard M. Doerflinger, *Washington Insider: Hobby Lobby and Conestoga: A Victory for Religious Freedom*, 14 NAT'L CATH. BIOETHICS Q. 409, 412 (2014).

¹³⁴ See Remarks by the President on Preventive Care, *supra* note 128.

¹³⁵ *Wheaton College v. Burwell*, 134, S.Ct. 2806 (2014). Wheaton College, a religious nonprofit entity, refused to file an EBSA Form 700 objection to an issuer or TPA because it believed that doing so would make it complicit in an immoral act. In attempting to avoid material cooperation with the immoral act while still abiding by the law, the college instead filed an objection with the HHS Secretary. The Court enjoined enforcement with respect to both the agency form and its regulatory filing process. The Court concluded: "Nothing in this order precludes the Government from relying on this notice, to the extent it considers it necessary, to facilitate the provision of full contraceptive coverage under the Act." *Id.* at 2807.

¹³⁶ Press Release, U.S. Conf. Cath. Bishops, HHS Final Rule Still Requires Action in Congress, by Courts, Says Cardinal Dolan (July 3, 2013), *available at* <http://www.usccb.org/news/2013/13-137.cfm>.

¹³⁷ 134 S.Ct. 2751 (2014).

run by human beings worthy of Constitutional protection.¹³⁸ It also recognized that the matter presented a philosophical and religious question and that imposing coverage over moral objection was tantamount to wrongly “tell[ing] the plaintiffs that their beliefs are flawed.”¹³⁹ In accord with this conclusion, the Court held that the ACA’s contraceptive mandate, as applied to non-religious, for-profit, closely held corporations, unconstitutionally burdened the free exercise of religion of those who ran the entities.¹⁴⁰

The agency acquiesced in the Court’s rulings, and once again modified its regulation. A new agency proposal extended accommodations to closely held, for-profit, non-religious entities. In addition, it permitted qualifying entities to submit objection notices to the HHS Secretary. When the Secretary received notice, HHS, and not the objecting religious entities, was charged with directing plan insurers and TPAs to carry out preventive coverage activities.¹⁴¹

As a result of the recorded series of rulings, religious employers, non-profit religious organizations, and closely held, for-profit, secular companies will not be forced to directly provide for morally objectionable “preventive” coverage. However, remaining unprotected are the moral values of those who run secular, for-profit entities that are not eligible for any exemption or accommodation. Also unresolved is how to preserve religiously-affiliated entitlement to exemption or accommodation when those entities partner with secular, for-profit corporations. The religiously-affiliated entities are placed in a very difficult position. They will find it challenging to preserve their service missions while also retaining their religious identity and commitment to moral principles.¹⁴²

¹³⁸ *Id.* at 2768.

¹³⁹ *Id.* at 2778.

¹⁴⁰ *Id.* at 2779-2781

¹⁴¹ *Women’s Preventive Services Coverage and Non-Profit Religious Organizations*, *supra* note 126. 29 C.F.R. § 2590.715-2713A(b)(ii) & (c)(1) (2014) (self-certification could be sent to TPA, insurance issuer, or HHS secretary).

¹⁴² Elizabeth Ramage, *Pope Francis on Health Care*, 14 NAT’L CATH. BIOETHICS Q. 421, 425-26 (2014).

H. Unsatisfactory Consideration of Spiritual Health

The parsimonious action taken in response to the significant – and expressed – moral concerns evidences a poor attitude about the spiritual well-being of citizens. There is either a lack of awareness, or an unwillingness to assiduously support spiritual health.

The House Committee on Oversight and Government Reform expressed concern about this matter. It asserted that the series of administrative revisions were not really about protecting conscience. Instead, the Committee regarded them as manipulative tactics that were “part of a larger strategy by the Administration to prevent courts from hearing challenges to the contraception mandate.”¹⁴³ Indeed, consistent diversion of case dispositions to procedural closures evidences fear that substantive objections had legal, as well as moral validity.¹⁴⁴

One cannot ignore the House Committee’s admonition

¹⁴³ Letter from Darrell Issa, Chair, Committee on Oversight & Gov’t Reform & Jim Jordan, Chair, Subcommittee on Econ. Growth, Job Creation & Reg. Affairs, to Kathryn Ruemmler, Couns. to President (Oct. 22, 2013), *available at* http://oversight.house.gov/wp-content/uploads/2014/05/2013-10-22-DEI-_Jordan-to-Ruemmler-WH-IRS-communications-and-equities-due-11-5.pdf. One commentator described the series of revisions an accommodation “shell-game.” Michael Stokes Paulsen, *2014 Supreme Court Roundup*, *FIRST THINGS*, 1, 27, 30 (Nov. 2014).

These criticisms of the executive branch come on the heels of another allegation of White House involvement with unfair IRS targeting of conservative organizations. *See, e.g.*, Robert W. Wood, *20 Facts About IRS Targeting, Those E-mails and the White House*, *FORBES* (Dec. 17, 2014, 1:20 a.m.), <http://www.forbes.com/sites/robertwood/2014/12/17/20-facts-about-irs-targeting-emails-and-the-white-house/>; Zachary A. Goldfarb & Karen Tumulty, *IRS Admits Targeting Conservatives for Tax Scrutiny in 2012 Election*, *WASH. POST*, May 10, 2013, http://www.washingtonpost.com/business/economy/irs-admits-targeting-conservatives-for-tax-scrutiny-in-2012-election/2013/05/10/3b6a0ada-b987-11e2-92f3-f291801936b8_story.html.

¹⁴⁴ *See, e.g.*, *Wheaton College*, 134 S.Ct. 2806 (2014). The August 2014 revision avoided adjudication of Wheaton College’s complaints on the merits; the Court remedy was injunctive relief. *Id.* Only one of the 30 lawsuits filed by religious-affiliated nonprofit organizations was decided on the merits of the case. Therefore, the manipulations were largely successful. Letter from Darrell Issa & Jim Jordan, *supra* note 143.

regarding administrative motives. Plan B, IUDs, and all FDA-approved female contraceptives must be covered under insurance plans and must be provided free of charge. The same is not true for other pharmaceuticals and medical treatments. While the legislative purpose of the ACA is to improve the efficient delivery of quality healthcare, its highest order directive (evidenced by its mandate that female preventive services must be delivered without cost) may be more about imposing its view than about health per se.¹⁴⁵

President Obama declared that free preventive coverage was mandated in order save money. In support, he asserted that it was imposed “because it’s a lot cheaper to prevent an illness than to treat one.”¹⁴⁶ But pregnancy is neither a disease nor an illness. Therefore, with respect to the objected-to services that are included in this coverage group, the logical interpretation of his statement is that it is cheaper to prevent *birth* than to care for children who are born. As such, it expresses a preference to induce prospective mothers to avoid birth, and gives insufficient consideration to its interference with the spiritual health of those induced or those required to facilitate or to provide coverage.

Conclusion

In my introduction, I assumed that health is a human right. If there is a right to health, then there is some duty to promote it. The duty may have been discharged even before the enactment of the Affordable Care Act. To the extent that the ACA proposes to improve the efficient delivery of quality healthcare, it is a praiseworthy endeavor. But, as revealed in this essay, there are flaws

¹⁴⁵ See Stanley Carlson-Thies, *Which Religious Organizations Count as Religious? The Religious Employer Exemption of the Health Insurance Law’s Contraceptives Mandate*, ENGAGE, 13 (July 2012), <http://www.fed-s0c.org/publications/detail/> (postulating that governmental determination of who does or who does not meet the exemption/accommodation criteria has “great religious-freedom significance . . . because they embody a governmental conception of what is authentic religion”). See also U.S. Conf. Cath. Bishops, *supra* note 110, at 14-15.

¹⁴⁶ Remarks by the President on Preventive Care, *supra* note 128.

that need to be reassessed.

Efficient delivery of quality healthcare to poor families may be undermined by some ACA strategies. The ACA-imposed MAGI accounting system for determining eligibility will push some poor parents out of Medicaid. Members of this group and other relatively healthy people who must purchase insurance coverage on an exchange are placed in a position where they may receive less medical care than before enactment of the ACA. Even if eligible to receive tax credits, many may find it more economical to pay the penalty for non-coverage than to obtain insurance on an exchange – especially in light of the high out-of-pocket expenses that must be paid by the insured when care is received under a plan. Access to providers and non-generic pharmaceuticals may also decrease with the cost-shifting strategies of the ACA. Therefore, some restructuring is needed to avoid these pitfalls. In addition, the ACA and its implementation should give greater consideration to a holistic view of health.

An assessment of health is much broader than a mere consideration of whether there is affordable access to appropriate treatments for physical and mental ailments. It encompasses a holistic view of human flourishing. A core aspect of human flourishing includes spiritual health. This aspect of overall health is undermined by the preventive coverage mandate. To relieve the burdens of individuals whose consciences suffer by the ACA's preventive care impositions, the morally objectionable portions of the preventive coverage mandate should be severed. Instead, plans and employers should – at the very least – be granted the freedom to choose whether to provide ACA “suggested” preventive coverage.

Severing the morally objectionable portion of the ACA and reworking some of the cost-shifting mechanisms will improve health and more closely align it with human rights principles of promoting human flourishing.