

**LOOKING BACK AND LOOKING FORWARD:  
CELEBRATING ANNIVERSARIES BY ANTICIPATING THE  
IMPLEMENTATION OF THE AFFORDABLE CARE ACT**

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I. CELEBRATING ANNIVERSARIES

This Symposium marks the 30th anniversary of *The Social Transformation of American Medicine*,<sup>1</sup> Paul Starr's Pulitzer Prize-winning book. Health law and policy scholars uniformly recognize this book as one of the most influential texts ever written about the medical profession and the healthcare system. The highly respected *Journal of Health Policy, Politics & Law* celebrated the book's 20th anniversary with an entire issue devoted to analyzing its impact on health law and policy and on health law as an academic field.<sup>2</sup> One well-accepted measure of the impact of scholarly work is the number of times a book or article is cited in the scholarly literature. By that measure, the impact of Professor Starr's book is extraordinary. As of ten years ago, in legal scholarship alone, the book had been cited at least 1,400 times in more than 433 law review articles,<sup>3</sup> and the Science Citation Index logged over 2,000 citations.<sup>4</sup> Legal scholars have noted that this book "redefined how lawyers think about medicine."<sup>5</sup> It crossed ideological lines so that "[l]egal scholars from a wide range of perspectives found the book an elegant, accessible, and comprehensive history" that supported diverse visions for change.<sup>6</sup> We are happy and grateful to be able to celebrate the 30th anniversary of Paul Starr's landmark work, and his continuing influence on health policy, with this Symposium.

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1. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

2. *Transforming American Medicine: A Twenty-Year Retrospective on the Social Transformation of American Medicine*, 29 J. HEALTH POL. POL'Y & L. (SPECIAL ISSUE) 557 (2004).

3. Timothy S. Jost, *The Uses of The Social Transformation of American Medicine: The Case of Law*, 29 J. HEALTH POL. POL'Y & L. (SPECIAL ISSUE) 799, 799 (2004).

4. Joel D. Howell, *What the Doctors Read*, 29 J. HEALTH POL. POL'Y & L. (SPECIAL ISSUE) 781, 783 n.3 (2004).

5. Jost, *supra* note 3, at 808 (quoting Sara Rosenbaum during an interview with Jost).

6. *Id.* at 807.

The Center for Health Law Studies at Saint Louis University School of Law is also celebrating the 30th anniversary of its formal founding. We are delighted to celebrate this anniversary in the manner in which we have always done our work — by engaging in scholarship and teaching that is firmly rooted in the context of healthcare.

It all began in a bar and with notes sketched on a napkin — really. The conversation began with a question: *if* we were going to do “something” in “health law,” what would it look like? Over the following thirty years, the answer to that question produced over 1,100 SLU health law alumni practicing in law firms, government agencies, and public interest advocacy groups across the entire nation; provided pre-tenure scholarship workshops for more than 40 new health law scholars; and published more than 30 law review symposium issues on critical issues in health law and policy and launched a journal dedicated entirely to the field. The ten faculty members currently working in the Center include four professors who have received the Health Law Teacher Award from the American Society of Law, Medicine, & Ethics and authors of two leading casebooks in the field. Law students can now select from a rich health law curriculum that offers more than 20 courses each year, including several clinical and externship opportunities. They can pursue one of our five dual degree programs. Students can spend a Health Law Semester in Washington, D.C., working in key federal agencies. And the list goes on.

But it didn’t begin that way. In fact, it didn’t begin 30 years ago. Actually, we “found” the Center within several bits and pieces that were already thriving at SLU for at least half a dozen years by that time. By the mid-1970s, Professor Mike Wolff was offering a nascent health law course (taught out of a binder of materials he had put together); and Professor Jesse Goldner was offering a course in Law & Psychiatry, which brought together law students and residents in psychiatry from our Medical School. During that same time, the School had admitted its first class to the joint JD/MHA program, one of the first in the country. An early leader in clinical education generally, the School of Law already offered two clinics in what would now be considered health law. The School of Law operated a Mental Health Law Clinic, representing patients of a state psychiatric facility, and had a federally funded clinic for not-for-profit organizations that focused on serving the needs of not-for-profit healthcare organizations, including one of the early federally qualified health centers in St. Louis. The first law review Symposium conference was held in 1979 (focusing on the then new Missouri nursing home law), although special law review issues dedicated to health law predated even that event.

The formal organization of the Center for Health Law Studies, however, required us to give thought to a question that still occupies a contentious position — what exactly is health law? In 1982, the first casebook to be

entitled “Health Law” had not yet been published, after all. (That casebook, by the way, celebrated its 25<sup>th</sup> anniversary in 2012, and is entering its 7<sup>th</sup> edition.)<sup>7</sup>

Over beer and unhealthy food, we decided to have an expansive and inclusive definition of health law. Our napkin notes listed things like occupational health and insurance law, malpractice, and so on. We would count as health law any area of law that had a significant impact on healthcare. We still use the same working definition.

We also adopted a specific mission and particular strategies that guided our early work. The mission of our Center was and continues to be the education of law students for health law practice. This mission guided everything we did. It made us look for student opportunities in all of our work as scholars and in all of our programs. The mission led to a health law certificate program that provided for strong academic and career services advising and required both research and practice experience in addition to classroom coursework. It also led to our establishing our first colloquium series 30 years ago so that our first-year students, who are not able to take any health law courses, could ramp up their knowledge base. The colloquium series eventually morphed into the Distinguished Speaker Series and the annual Practitioner in Residence program. Our mission drove us, but that is only because the students at SLU were driving us to do more — always. The Health Law Student Association formed in 1983 and became a significant partner in fashioning the future of the Center.

We were very aware that health law was an emerging field and was likely to change quickly over time. We intentionally adopted four general strategies that would guide us in our early years and still characterize the Center’s planning and programming.

First, we wanted the Center to have a high degree of engagement with health law practice and the healthcare delivery system. We believed that this engagement would lead to better teaching, better scholarship, and more opportunities for our students. The formation of the health law alumni network was one of our first efforts and it was a critical step as so many of our alumni were pioneering the field. Faculty members also took on a heavy load of service on IRBs, ethics committees, law reform commissions, bar association committees, and other positions that would immerse us in the work of health law and policy.

Second, we believed that the work had to be interdisciplinary. That seems obvious today, but in the late 1970s and early 1980s, interdisciplinary work was still suspect in the legal academy. The interdisciplinary approach has proven to be very powerful in law generally

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7. BARRY FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS (7th ed. 2013).

and essential to health law. Early on, we had to work at creating opportunities for interdisciplinary collaboration, which we did by getting joint faculty appointments in several departments in the University's School of Medicine, School of Public Health, and Department of Health Care Ethics. We sought out opportunities to co-teach and to co-author articles across disciplinary lines.

Third, we built partnerships. We committed to working with everyone who was interested in working with us. Our early partners — the American Society of Law & Medicine (now, the American Society of Law, Medicine & Ethics) and the National Health Lawyers Association (NHLA; now the American Health Lawyers Association) — were invaluable to us. We partnered on conferences, on projects, and in resources. We hosted the first Health Law Teachers Meeting outside of Boston, and our library became a depository for all NHLA publications and conference materials. We partnered with our sister schools at SLU, including the Schools of Medicine, Nursing, Allied Health, Public Health, and the Center for Health Care Ethics. We worked with a number of law schools setting up health law centers themselves and appreciated the mutual learning that took place and the life-long professional colleagues we gained.

Fourth, we built a health law faculty by keeping things fluid. We decided at the very beginning that being a "health law" faculty member at SLU was going to be inclusive rather than exclusive. If one of our colleagues in a particular area — for example, in employment law or insurance law — was doing something related to healthcare, we would pull them in. We decided that all of our health law faculty would teach a "bread-and-butter" course in addition to health law courses. In fact, we went along for the first 20 years without hiring a single person specifically because they were in health law, but we got great health law teachers and scholars who were attractive to the rest of the school because they taught Antitrust or Civil Procedure or another necessary course. In hindsight, this approach bears a great resemblance to how the law firms built their health law departments and how they continue to serve their health law clients. My faculty colleagues are terrific scholars with a broad understanding of health law and a deep knowledge in their particular specialty. We each specialize in the slice of health law for which we have the greatest passion, whether healthcare access or antitrust, disability rights or healthcare financing, regulation of research or end-of-life care, neuroethics or malpractice.

The napkin project has worked well for us over these years. In a more thorough history of the Center, each individual — faculty, staff, and student — who helped to build the Center would be recognized by name. Suffice it to say, that each contribution — taking a turn as Director, gaining external funding, making just the right contacts to secure a position for a student, writing great articles, mentoring new faculty, planning a conference, editing

a journal, taking care of our distinguished guests, serving on yet another board or commission — have all been critical to developing and continuing the work of the Center for Health Law Studies at Saint Louis University School of Law.

## II. ANTICIPATING THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

Our current healthcare delivery system is essentially the house that Medicare built. With the advent of the Affordable Care Act (ACA), we have entered a major renovation project — neither a gut rehab nor a superficial patch-and-paint job. As the history of health reform has taught us, decisions made in the implementation stage of the grand schemes of transformation can place the entire reform effort at risk of failure. The work to move the ACA beyond paper is just beginning in earnest. This implementation effort will take place in many arenas — certainly in the federal administrative agencies, but also possibly in Congress as amendments or ancillary initiatives are needed, in 50 state legislatures and multitudes of state administrative agencies, and quite importantly, with the general public.

This Symposium Issue of the Journal grapples with some of the major challenges and opportunities presented in decisions facing those responsible for implementing the ACA. The articles — much too rich to summarize fully in this introduction — provide detailed, contextual, and insightful analyses. Taken as a whole, they strike several significant themes.

First, all of the authors draw on lessons from past efforts to inform the future. Second, the scholars writing in this Symposium issue provide strong evidence that the politics of reform do not end with enactment of big legislation. Finally, the implementation of the ACA will work within the framework of the existing healthcare system and will confront entrenched business and personal behaviors that run counter to the goals of the Act. The ACA's renovation of the healthcare system is not an entirely new construction, and anyone who owns an old house knows that repairs and rehabbing are more difficult and less predictable than building anew.

### A. *Past as Prologue*

For Paul Starr, our keynote author, a lesson that must be learned from past federal health policy initiatives is that pragmatic compromises on essential points may produce generations-long dysfunctions.<sup>8</sup> Professor Starr looks back to the formation of the Medicare and Medicaid programs. He identifies political expediency in the enactment of these programs as the

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8. Paul Starr, *Law and the Fog of Healthcare: Complexity and Uncertainty in the Struggle over Health Policy*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 213 (2013).

driver of our fragmented, bureaucratically complex, and costly healthcare system.

Professor Starr carefully documents in great detail the decisions that were made to compromise competing views and interests at the programs' inception and that led to a system characterized by what he calls "gratuitous complexity." He traces how these choices produced at least four separate federal healthcare programs, including the federally owned and operated Veterans Administration system; the Medicare program for seniors that itself is a mishmash of public insurance and private supplementary insurance; the state-federal Medicaid system, with a significant cost investment in rules and determinations of eligibility to confine its reach to certain defined segments of the poor, including a very significant portion of the elderly who need long-term care which is not covered by Medicare; and finally employer-provided insurance programs, supported significantly by foregone federal tax revenue.

The compromises in the design of Medicare and Medicaid were driven largely by political pragmatism. According to Starr, comprehensive reform proposals, including the ACA, are hampered by similar decisions. He identifies two politically expedient compromises that threaten the ultimate success of the ACA.

First, in Starr's view, the campaign to make the ACA acceptable to the broader public — with statements that "if you like your insurance, you can keep it" — was itself a significant compromise of the goal of health insurance market reform and builds in an expensive and unproductive complexity. In effect, this compromise burdens the ACA with our inefficient and costly private health insurance system and missed an opportunity to reduce administrative complexity and substantial costs.

Second, the decision to allow state health insurance exchanges to act as mere clearinghouses rather than requiring them to create regulated markets for health insurance made the exchanges more acceptable across the political spectrum. According to Professor Starr, however, this compromise is likely to allow insurers to market selectively and thus continue to cherry-pick desirable enrollees. Weakening the exchanges greatly undermines the market-enhancing goal of the health insurance exchanges and the risk-spreading strategy inherent in the ACA's insurance mandate.

Professor Tim Greaney draws attention to experience in Medicare as a tool for understanding the challenges presented in achieving the ACA's goals regarding cost control.<sup>9</sup> He details the design and implementation of past Medicare payment reforms, the DRG (Diagnostic Related Groups)

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9. Thomas L. Greaney, *Controlling Medicare Costs: Moving Beyond Inept Administered Pricing and Ersatz Competition*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 229 (2013).

system put in place 30 years ago next year, and the RBRVS (Resource-Based Relative Value Scale) system put in place 20 years ago this year. While the DRG system achieved some success in controlling payments to hospitals, the pricing controls raised administrative costs significantly. The RBRVS system was a total failure in Greaney's view, as it achieved neither of its core goals. It failed to shift value to primary care from specialty care, due to the disproportionate political influence organized around specialty care. It also failed to reduce overall volume, likely because Congress holds the authority to apply the volume controls.

Professor Greaney's article illustrates at least three lessons to be learned from past experience with Medicare cost-control. First, payment systems need to be concerned with quality and effectiveness of care as much as payment in the effort to reduce overall costs. Second, working around the edges of the fee-for-service payment system, which Professor Greaney calls the *bête noire* of the system, promises little significant change. Finally, relying on political will to control volume or price is futile. With these warnings in hand, however, Greaney is at least somewhat optimistic that the reforms that the ACA promises in reorienting the payment and delivery system can succeed.

#### B. *Political Battles Continue*

The political battle over the ACA clearly did not end with its passage in 2010. It continued at a fever pitch through the Supreme Court's issuance of its decision in *National Federation of Independent Business v. Sebelius*,<sup>10</sup> and through President Obama's reelection. Neither of these watershed events, however, settled the political turmoil. In fact, political battles over the ACA will continue in Congress during the amendment process, at the administrative agencies as they make choices about the details, and in state legislatures as they make their decisions about the Medicaid expansion and the exchanges.

Up to this point in the life of the ACA, the Obama Administration has made a tremendous effort to avoid the amendment process due to concerns that opening the door for any legislative action would result in the repeal or gutting of the entire Act. The most well known example is the Executive Order around abortion funding.<sup>11</sup>

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10. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

11. Exec. Order No. 13,535: Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act, 75 Fed. Reg. 15599 (March 29, 2010).

In her article, Professor Sara Rosenbaum argues persuasively, however, that all legislative reform is evolutionary.<sup>12</sup> The big legislative enactment necessarily is followed by a series of smaller bills or amendments to make modifications required as the implementation process moves forward. It is likely that ACA-related matters will have to come before Congress, and Professor Rosenbaum maintains that there are still strong political forces marshaled against the ACA.

Professor Rosenbaum argues that Medicaid, which carries the greatest expansion of coverage under the ACA, is especially vulnerable politically and that the “ferocious politics” of Medicaid will continue. She notes that the future of Medicaid, whether it becomes a part of a comprehensive healthcare system or is dismantled, will be an “intensely political determination rather than one driven by health policy.”

Professor Sidney Watson provides insights into why the political environment for Medicaid has been so treacherous.<sup>13</sup> She argues that Medicaid has been politically vulnerable because it has been the program for “others,” specifically the poor, and so has not enjoyed the broad support that protects Medicare. She effectively demonstrates, however, that the notion that Medicaid covers “the poor” is mistaken. Watson documents the significant volatility in incomes that produces a great deal of movement into and out of Medicaid as individuals’ financial situation changes. Further, especially for coverage of nursing home care, Medicaid covers the mothers of large numbers of “not poor” adult sons and daughters. Professor Watson holds out hope that the expansion of Medicaid under the ACA will remove the stigma from “Old Medicaid” and give Medicaid the dignity of a social insurance program.

For implementation of big legislation, decisions made by administrative agencies are critical. The big questions, such as whether coverage for preventive care must include contraceptives, garner all the headlines; however, less dramatic decisions are more likely to determine whether the ACA succeeds. Professor Rosenbaum highlights two significant administrative decisions that have attracted little attention.

First, like Professor Watson, Professor Rosenbaum points to the substantial movement of individuals into and out of Medicaid and into and out of private insurance as individual incomes fluctuate over relatively short periods of time. She argues that the decision by the Centers for Medicare & Medicaid Services to allow the health insurance exchanges to move individuals out of the exchanges for Medicaid determination will thwart the

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12. Sara Rosenbaum, *Medicaid’s Next Fifty Years: Aligning an Old Program with the New Normal*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 329 (2013).

13. Sidney D. Watson, *Embracing Justice Roberts’ “New Medicaid”*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 247 (2013).

ACA's goal of improving the quality of care. It does this by guaranteeing that a very large number of people experience serial breaks in coverage, as they shift between Medicaid and private insurance or no coverage, and that these disruptions will make continuity of care more difficult.

A second administrative decision highlighted in Professor Rosenbaum's article is the decision to use existing private health insurance plans as the benchmark for the content of the essential benefits package. By doing this, it is possible that the Secretary of the Department of Health & Human Services avoided tremendous political fights, both of the ideological sort and the run-of-the-mill special interests. Rosenbaum argues, however, that this one decision will result in terribly inadequate health services for the disabled despite the Act's prohibition against disability discrimination. Current private health insurance plans, which Rosenbaum contrasts with the more adequate Medicaid benefits for the disabled, carve out services, medications, and equipment or supplies needed to maintain the health of these individuals, thereby resulting in poor care and poor outcomes.

Professor Rosenbaum hopes that these deficiencies in the current administrative decisions will be corrected. She suggests that this could be accomplished if CMS would allow the states discretion on issues regarding Medicaid eligibility.

### C. *Rebuilding within Existing Frameworks*

The ACA is visionary legislation that aims at profound change on so many levels. For example, the ACA hopes for nothing less than a fundamental change in the way that medicine is practiced. The ACA demands that medicine move toward 1) more evidence-based decision making; 2) an emphasis on primary care and away from specialty care and interventions; 3) an interprofessional team approach, with leadership drawn from other health professions; and 4) management of chronic diseases, where the skill set of medicine may not match up favorably to the skill set of nursing. These and other key ACA reforms require changes in established behaviors.

Although nothing was easy in drafting and enacting the ACA, writing behavior change on paper is much easier than actually changing behavior. First, achieving change requires a clear understanding of behavior patterns, on both a business and personal level, induced by the current payment and delivery systems. Professor Greaney's article, for example, highlights behaviors that respond to the current fee-for-service payment system. Second, changing behavior requires a deep understanding of how individuals and organizations respond to legal, financial, and social threats and incentives. Without this understanding, it is likely that applying these tools will fail to produce the intended behavior change. Both Professor Mark

Hall and Professor Brietta Clark address the challenge of behavior change under the ACA.

In his article, Mark Hall presents the results of his study examining the operation of the health insurance exchange in the State of Massachusetts, established under that State's precursor to the ACA.<sup>14</sup> He extrapolates from that study to anticipate the conditions and strategies required for success for the ACA health insurance exchanges. Professor Hall's case study tells the tale of the struggle to insert a new instrument into an established market. For example, the Massachusetts exchange has faced significant difficulties in changing established business behaviors in the insurance markets, and Hall illustrates how jockeying for competitive advantage within the insurance market can affect the success of the exchanges. The Massachusetts exchange also has struggled to establish its value-added proposition to the satisfaction of insurers and employers with the result that those parties have continued to follow well-established patterns of work. Overall, the Massachusetts exchange has not created the level of activity that was expected. On the positive side, Professor Hall notes that the insurance market in Massachusetts had changed in a positive direction, under the Massachusetts health reform, prior to the establishment of the exchange. He is also hopeful that having the federal subsidies flow through the ACA health insurance exchanges will drive business to them, allowing them some leverage in working health insurance market reform.

Professor Brietta Clark tackles a substantial uncertainty lurking within the core of the ACA.<sup>15</sup> She asks: will individuals consistently make the decision to secure health insurance coverage in advance of acute need, either by purchasing private coverage or by applying for Medicaid, or will the choice allowed by the rather light penalty/tax become the default with the result that the mandate fails to achieve its goals? Professor Clark's analysis is firmly anchored in behavioral sciences. She is clear that policymakers need to take into account the established patterns of behavior even when behavioral change is the desired outcome. She appreciates the impact of language and vision as strategies for behavioral change on a large scale and, in particular, the expressive power of the law. According to Professor Clark, policymakers must undo the implicit message about health care that has been sent by law and social norms over the past several decades. That message is that there is no right to health care and that each person is on his or her own. In fact, the risk rating in place over the last two decades embedded a conviction that my health insurance premiums should

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14. Mark A. Hall, *Employers' Use of Health Insurance Exchanges: Lessons from Massachusetts*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 355 (2013).

15. Brietta Clark, *A Moral Mandate & the Meaning of Choice: Conceiving the Affordable Care Act After NFIB*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 267 (2013).

advantage my healthy status over those who are sickly rather than spreading the risk of illness and injury over the entire population. Clark tells a compelling story as she analyzes the expressive power of the ACA generally and the debate over the mandate/tax in particular. She persuasively argues that a “moral mandate” will be required to drive behaviors toward the mutual responsibility and solidarity required for a robust commitment to insurance and for the success of the ACA.

Professor Clark also engages in the struggle to identify the triggers and levers that will induce the required behavioral change. For example, she applies what is known about the impact of social norms and legal sanctions to examine whether people will choose to purchase insurance or pay the penalty/tax to the IRS. If large numbers of individuals choose to opt out of insurance coverage, the ACA’s vision of increased solidarity and its goals of improved access are likely to collapse. According to Clark, it will matter whether the payment is viewed as a legal sanction for poor behavior which is to be avoided or whether it is viewed as a calculated financial choice that is entirely legitimate. She holds out hope, though, that the ACA will instill a “moral obligation to support the collective good by participating in the insurance market.” This hopefully will help people embrace and internalize this “new moral norm.”

The fine articles in this Symposium Issue will make a significant contribution to understanding the decisions that must be made to make the vision of the ACA a reality. They also provide a guide to both the anticipated and unintended consequences of those decisions.

