

HEALTH CARE FOR LOW-INCOME CLASSES IN AN INDIVIDUAL MANDATE SYSTEM: LESSONS THE UNITED STATES CAN LEARN FROM SWITZERLAND

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I. INTRODUCTION

The United States is currently moving forward with a dramatic overhaul of its health care system as landmark legislation begins to take effect.¹ Long defined by laissez-faire principles, U.S. health care became fraught with what many consider unsustainable costs,² and thus became subject to unprecedented government intervention. However, as decades of presidents and congressmen have learned,³ reforms that would abandon the market competition so essential to the existing system—reforms modeled after Great Britain or Japan, for example⁴—are political nonstarters in the U.S.⁵

This longstanding tension between individualism and regulation is the context in which President Barack Obama signed the Patient Protection and Affordable Care Act (the PPACA) into law in March 2010.⁶ An ambitious law that takes aim at virtually the system's every nit, the PPACA broadly sought to reconcile small-government values—enjoying a popular renaissance at the time thanks to widespread government deficits⁷—with a social conscience disturbed by years of inequitable health care.⁸

One issue that has permeated nearly all debates over U.S. health care reform is access. Health disparities among socioeconomic classes are strikingly high in the U.S. compared to most of the developed world.⁹ Thus,

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of I.R.C. and 42 U.S.C.).

² See MICHAEL TANNER, CATO POL'Y ANALYSIS NO. 613, THE GRASS IS NOT ALWAYS GREENER: A LOOK AT NATIONAL HEALTH CARE SYSTEMS AROUND THE WORLD 2-3 (2008) (arguing that health care costs rising faster than GDP growth, along with rising debts of government health programs, threaten to burden the U.S. economy in perpetuity if unaddressed).

³ See David Pratt, *Health Care Reform: Will it Succeed?*, 21 ALB. L.J. SCI. & TECH. 493, 497-500 (2011) (summarizing past reform efforts).

⁴ TANNER, *supra* note 2, at 15-18, 23-25.

⁵ Pratt, *supra* note 3, at 498-99.

⁶ *Id.* at 495.

⁷ See *Washington Post-ABC News Poll*, WASH. POST, http://www.washingtonpost.com/wp-srv/politics/polls/postpoll_011610.html?sid=ST2010011701314 (last visited Oct. 21, 2012) (polling Americans in January, 2010, 58% of which said they preferred smaller government with fewer services).

⁸ Barack Obama, Op-Ed, *Why We Need Health Care Reform*, N.Y. TIMES (Aug. 15, 2009), <http://www.nytimes.com/2009/08/16/opinion/16obama.html> (appealing directly to the public regarding health reform and focusing on those who could not afford insurance, were denied coverage because of medical histories, or were victims of other insurance practices such as high out-of-pocket expenses).

⁹ See Michael de Looper & Gaetan Lafortune, *Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries* 25, 32 (Org. for Econ. Cooperation and Dev., OECD Health Working Paper No. 43, 2009), available at [http://search.oecd.org/officialdocuments/displaydocumentpdf/?doclanguage=en&coteDELSA/HEA/WD/HWP\(2009\)2](http://search.oecd.org/officialdocuments/displaydocumentpdf/?doclanguage=en&coteDELSA/HEA/WD/HWP(2009)2) (showing that the U.S. fares poorly in two key metrics: (1) odds of fair or poor health in lower socioeconomic groups compared to higher income groups and (2) health insurance coverage

policy considerations as to how health care should be provided to low- and middle-income classes, and who should pay for it, guided many of the reforms effectuated by the PPACA.¹⁰ Two particularly relevant, and controversial, elements of the Act are (1) the expansion of Medicaid, the existing state and federal government program for insuring the poor, and (2) the implementation of health insurance exchanges through which individuals can purchase private insurance.¹¹ These provisions arose under the PPACA's individual mandate, which requires all U.S. citizens to purchase health insurance or pay a penalty.¹² The PPACA helps low-income individuals satisfy this requirement by expanding Medicaid to cover those with incomes up to 133% of the federal poverty level and admitting into the program childless adults, who were previously excluded.¹³ The Act helps others with the costs of the individual mandate by establishing state-based health insurance exchanges.¹⁴ These exchanges are intended to facilitate the purchase of private insurance by regulating the plans eligible to be sold therein and subsidizing certain plans based on the purchasers' household incomes.¹⁵

However, any federal law attempting to move mountains socially must act within the procedural limitations of U.S. federalism. Extensive controversy and litigation followed the passage of the PPACA, most of which related to the federal government's ability to impose the law on unwilling states.¹⁶ Among its many federally administered regulations, the original version of the law required states to expand their Medicaid programs or lose all federal support for Medicaid.¹⁷ After hearing an appeal from twenty-six states, the U.S. Supreme Court held in June 2012 that the PPACA's mandatory Medicaid expansion constituted coercion toward the states and could not be upheld.¹⁸ The decision, *National Federation of Independent Business v. Sebelius*, left the rest of the law intact but limited the federal government's enforcement authority regarding the Medicaid

for a core set of services).

¹⁰ See Obama, *supra* note 8 (identifying the struggle of 46 million people to pay for health insurance as the primary issue targeted by the PPACA).

¹¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of I.R.C. and 42 U.S.C.).

¹² THE HENRY J. KAISER FAMILY FOUND., SUMMARY OF THE AFFORDABLE CARE ACT 1, <http://www.kff.org/healthreform/upload/8061.pdf> (last updated Apr. 15, 2011) [hereinafter SUMMARY OF THE AFFORDABLE CARE ACT].

¹³ Pratt, *supra* note 3, at 520.

¹⁴ 42 U.S.C.A. §§ 18021–18063 (2010).

¹⁵ Pratt, *supra* note 3, at 515–16.

¹⁶ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 *passim* (U.S. 2012).

¹⁷ *Id.* at 2582.

¹⁸ *Id.* at 2604.

expansion.¹⁹ This effectively made such an expansion optional, with no threat to states' existing Medicaid programs.²⁰

As a result, many state leaders have announced their intentions to decline the expansion.²¹ Furthermore, a majority of states opted not to establish their own health insurance exchanges by the deadline specified in the PPACA.²² Such obstinacy, particularly with respect to the insurance exchanges, could be hugely problematic when considered in conjunction with the rest of the health law. At a basic level, these states' low-income citizens would only enjoy more equitable health coverage if federally administered health exchanges were able to fill the resultant coverage gap.²³ If the federal exchanges fail to enroll the bulk of this population, it could have sweeping effects on the new insurance marketplace, which depends in various ways on widespread participation.²⁴

With so much uncertainty as to what form its health care system will eventually take, where can the U.S. look for guidance? This Note posits that the U.S. should look to Switzerland, a once-popular analogue in debates over U.S. health care reform.²⁵ Both as a model for implementing the new health

¹⁹ *Id.* at 2607–08.

²⁰ *Id.*

²¹ Brianna Ehley, *GOP Govs Fight with Hospitals over Medicaid Opt-In*, FISCAL TIMES (Aug. 20, 2012), <http://www.thefiscaltimes.com/Articles/2012/08/20/GOP-Govs-Fight-with-Hospitals-over-Medicaid-Opt-In.aspx#page1>.

²² Phil Galewitz, *Facing Deadline, Most States Say No to Running Their Own Insurance Exchanges*, KAISER HEALTH NEWS BLOG (Dec. 14, 2012, 9:51 AM), <http://capsules.kaiserhealthnews.org/index.php/2012/12/facing-deadline-most-states-say-no-to-running-their-own-insurance-exchanges>. Only eighteen states submitted proposals for state-run exchanges to the Department of Health and Human Services by the law's December 14, 2012 deadline. *Id.* States choosing not to establish their own exchanges have shifted that responsibility to the federal government. *Id.*

²³ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP'T OF HEALTH AND HUMAN SERV., GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES 3 (2012), available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf>; see also Galewitz, *supra* note 22. If states do not establish an exchange by January 1, 2014, the Secretary of the Department of Health and Human Services will be expected to have set up a federally administered exchange that will serve that state's citizens. Most analysts did not expect a majority of states to defer this process to the federal government, a reality that has raised questions about the federal government's capacity to establish exchanges for so many people. *Id.*

²⁴ See Rachel Kreier & Peter Zweifel, *Health Insurance in Switzerland: A Closer Look at a System Often Offered as a Model for the United States*, 39 HOFSTRA L. REV. 89, 93 (2011); see also Paul J. Donahue, *Federalism and the Financing of Health Care in Canada and Switzerland: Lessons for Health Care Reform in the United States*, 21 B.C. INT'L & COMP. L. REV. 385, 424–25 (1998).

²⁵ See generally Donahue, *supra* note 24 (considering the Swiss system as a possible model for U.S. reforms well before the inception of the PPACA); see also Nelson D. Schwartz, *Swiss Model for Health Care Thrives Without Public Option*, N.Y. TIMES, Oct. 1, 2009, at A1

law and a cure for any latent ills therein, Switzerland's health care system offers ample lessons for the U.S.²⁶ Indeed, the PPACA derives many of its elements from the Swiss system: an individual mandate, state-administered exchanges of private insurance, and government subsidies for low-income classes.²⁷ These approaches have proved compatible with Switzerland's democratic structure, which consists of one central government and twenty-three semi-autonomous cantons.²⁸ These cantons serve a role in the Swiss national health system similar to that U.S. states will be expected to serve under the PPACA. Perhaps most important, the Swiss system works: the rise of healthcare costs has slowed since its implementation, while coverage has expanded to virtually all citizens.²⁹

The U.S. should draw from Switzerland's experience as states consider how to best serve their low-income populations while simultaneously addressing budget deficits and other economic factors. Switzerland has shown that health insurance exchanges, which put individuals in control of their health care decisions, provide a viable alternative to welfare programs as a means of reducing health disparities.³⁰ This model, adopted in a modified form by the PPACA, should square with the individualistic ideologies of conservative leaders who oppose an expansion of Medicaid. This Note argues that states should embrace the insurance exchanges, or else risk worsening conditions for wide swaths of their populations.

First, Part II of this Note will explore some of the shortcomings of the U.S. health care system before the PPACA, focusing on access issues and rising costs, and then explain provisions of the PPACA that aim to rectify these problems. Part II will also introduce the Swiss health care system as an archetype for implementation of the PPACA. Part III will delve deeper into the choices U.S. states face with respect to enforcing these provisions, ultimately asserting that Switzerland's experience should give dubious state leaders confidence in private insurance exchanges as the right course of action for the U.S.

(discussing the emergence of the Swiss analogy in the political discourse immediately preceding the enactment of the PPACA).

²⁶ Kreier & Zweifel, *supra* note 24, at 90.

²⁷ *Id.*

²⁸ Donahue, *supra* note 24, at 409.

²⁹ Kreier & Zweifel, *supra* note 24, at 101–02.

³⁰ TANNER, *supra* note 2, at 28.

II. BACKGROUND

A. Access Issues in the U.S. Result from an Insurance System that Functions Inequitably Across Socioeconomic Lines

While the U.S. health care system is often heralded as one of the world's best, not all of its citizens receive such excellent care.³¹ In reality, health care in the U.S. works like any capitalist marketplace: people get what they pay for. According to a 2009 report, more than half of the low-income Americans who did not receive adequate health care failed to do so because of cost.³² The insurance market, currently under reform, did little to help this socioeconomic class,³³ as evidenced by the large number of low- and middle-income individuals who chose to forgo health insurance altogether.³⁴

The socioeconomic class at the center of this Note is comprised of lower- and middle-class Americans not enrolled in Medicaid. These individuals were not well served under the old system, and may not fare much better under some states' approaches to the PPACA. This group can be further broken down into three subsets: (1) adults who do not receive coverage through an employer because they are self-employed, unemployed, or working for a small employer; (2) low-income families that are not poor enough to qualify for Medicaid; and (3) childless adults, who are not covered under most states' existing Medicaid programs. Left to fend for themselves, these people had little bargaining power in the pre-PPACA insurance market, and were therefore charged comparatively high premiums.³⁵ Moreover, as the U.S. economy has weakened, more employers have passed health costs onto their employees in an effort to balance their budgets, causing even more individuals to forego the burden of purchasing personal health insurance.³⁶

³¹ See sources cited *supra* note 9.

³² MICHAEL DE LOOPER, ORG. FOR ECON. CO-OPERATION AND DEV., HEALTH AT A GLANCE 2009, at 143 (2009), available at <http://www.oecd.org/health/health-systems/44117530.pdf>. In this study by the Organisation for Economic Co-operation and Development (OECD), a multinational research group, "low-income" is defined as income below the national average, and "unmet care need" is defined as the failure to seek care; missed medical tests, treatment or follow-ups; or failure to fill prescriptions. *Id.*

³³ Kimberly Cogdell Boies, *Using the Flexibility of the Affordable Care Act to Reduce Health Disparities by Creatively Structuring Health Insurance Exchanges*, 26 J. CIV. RTS. & ECON. DEV. 1, 4 (2011).

³⁴ CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011, at 21 (2011), <http://www.census.gov/prod/2012pubs/p60-243.pdf>. As of 2010, when the PPACA was enacted, 16.3% of the U.S. population, roughly 50 million people, were without health insurance. *Id.*

³⁵ Boies, *supra* note 33, at 4.

³⁶ Pratt, *supra* note 3, at 504.

Predictably, higher insurance costs resulted in high numbers of uninsured citizens in the U.S. as compared to other developed nations.³⁷ In 2011, 15.7% of Americans were uninsured, a high number in light of the near-universal coverage of citizens in most other developed nations, including Switzerland.³⁸ The percentage of low-income citizens who chose not to buy insurance, 25.4% in 2011, was substantially higher than the population's average.³⁹ Historically, minority groups have uninsured rates higher than the national average, particularly Hispanics.⁴⁰ Young adults also struggled to obtain coverage under the old system; more than 27% of adults between the ages of nineteen and thirty-four went uninsured in 2011.⁴¹

Medicaid was designed to correct for the disproportionate access problems of disadvantaged classes, but the program's reach is subject to federal eligibility requirements as well as additional, discretionary state restrictions.⁴² Since the inception of Medicaid, states have had the authority to determine exactly what portion of their populations should have access to government-funded care, and some states have greatly restricted access to their Medicaid funds.⁴³ For example, in Mississippi, a yearly income of over \$8,200 makes one ineligible for Medicaid.⁴⁴ Texas and Louisiana define poverty even more conservatively, only allowing those with yearly incomes below \$5,000 to enroll in Medicaid.⁴⁵ Alternatively, the PPACA asks states to expand Medicaid coverage to a new national standard: up to 133% of the poverty level.⁴⁶ But with so many states promising to reject the expansion, the issue of low-income individuals falling through the cracks in the insurance market is still problematic.

³⁷ See DE LOOPER, *supra* note 32, at 143 (ranking the U.S. against twenty-nine other developed nations, only three of which had less than 95% of their populations insured).

³⁸ DENAVAS-WALT ET AL., *supra* note 34, at 22.

³⁹ *Id.* at 25. "Low-income," for the purpose of this statistic, is defined as those with household incomes lower than \$25,000. *Id.*

⁴⁰ *Id.* at 24 (noting 30% of Hispanics were uninsured in 2011, according to the study).

⁴¹ *Id.*

⁴² THE HENRY J. KAISER FAMILY FOUND., WHERE ARE STATES TODAY? MEDICAID AND CHIP ELIGIBILITY LEVELS FOR CHILDREN AND NON-DISABLED ADULTS 1-2 [hereinafter WHERE ARE STATES TODAY?], available at <http://www.kff.org/Medicaid/upload/7993-02.pdf> (last updated July 2012).

⁴³ Carla K. Johnson & Kelli Kennedy, *Anti-Medicaid States: Earning \$11,000 is Too Much*, DENV. POST (Aug. 15, 2012), http://www.denverpost.com/nationworld/ci_21313761/anti-medicaid-states-earning-11-000-is-too.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Pratt, *supra* note 3, at 520.

B. The Insurance Structure Driving the U.S. Health Care System is Partly to Blame for the System's High Costs

The U.S. spends more on health care than any other country in the world.⁴⁷ In recent years, health care spending has exceeded 17% of the nation's gross domestic product, compared to 8.8% in 1980.⁴⁸ The total U.S. health care expenditure per capita is almost twice that of any other country.⁴⁹ While it is axiomatic that a country offering superior care would spend more, no truism can explain away such exorbitant costs. Even the presumption that the U.S. offers superior care is debatable, as the U.S. system fares poorly on metrics such as life expectancy and infant mortality compared to nations with similar economies.⁵⁰ Even more troubling is that costs continue to rise faster than the rate of inflation.⁵¹ Given the country's rapidly aging population that requires more care and higher Medicare expenditures, the rate of healthcare costs is likely to rise further if unabated.⁵²

High costs are reflected in higher expenditures by health care providers, which in turn creates higher costs to both those paying medical bills out-of-pocket and those paying for health insurance.⁵³ Since 2002, health insurance premiums in the U.S. have risen by 97%,⁵⁴ helping to explain a culture in which insurance is often viewed as an undesirable option. Yet the risks are even graver when one chooses not to have insurance, or to have too little insurance, and is stuck paying for outrageously priced care when health needs arise.⁵⁵ Such nonparticipation affects both the patient and society at large. The uninsured patient will likely avoid basic and preventive care, and then may be unable to pay for more expensive emergency care that is later required.⁵⁶ This is exemplified by the fact that more personal bankruptcies in the U.S. result from medical bills than from any other cause.⁵⁷ Each failure to pay has ripple effects throughout the health care system, as the insolvent

⁴⁷ DE LOOPER, *supra* note 32, at 160. In 2007, the U.S. spent more than \$7,000 per person on health care. *Id.*

⁴⁸ Pratt, *supra* note 3, at 579.

⁴⁹ DE LOOPER, *supra* note 32, at 160. The second-highest health care expenditures per capita in 2007 were those of Norway, which spent \$4,763 per person on health care. *Id.*

⁵⁰ Pratt, *supra* note 3, at 495 n.1.

⁵¹ TANNER, *supra* note 2, at 2.

⁵² Anna M. Rappaport, *Policy Environment for Health Benefits: Implications for Employer Plans*, 43 DEPAUL L. REV. 1107, 1111 (1994).

⁵³ Susan Alder Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?*, 39 CAL. W. L. REV. 303, 311–12 (2003).

⁵⁴ Chad Terhune, *Health Coverage Prices Rise 4%*, L.A. TIMES (Sept. 12, 2012), <http://articles.latimes.com/2012/sep/12/business/la-fi-employer-health-costs-20120912>.

⁵⁵ Pratt, *supra* note 3, at 506.

⁵⁶ *Id.*

⁵⁷ *Id.*

patient's unpaid treatment costs are ultimately absorbed by those paying taxes and insurance premiums.⁵⁸

Costs are also relevant to this discussion insofar as they play a major role in each state's calculus regarding the PPACA's government-spending provisions. While the federal government initially will cover 100% of the added Medicaid costs, its contribution will gradually diminish.⁵⁹ State governors facing budget deficits are reluctant to adopt a long-term spending plan that will eventually cost their states billions.⁶⁰ However, there are also reasons to think the Medicaid expansion would lower costs. As with the insurance exchanges, putting more insured patients into the system would help curtail the epidemic of uncompensated care.⁶¹ These diverging views will be detailed later, leading to the conclusion that the PPACA's insurance exchanges can lower costs while expanding coverage.

C. Relevant Provisions of the PPACA

The PPACA is a labyrinthine law, addressing a host of issues that currently plague the U.S. health care system.⁶² This Note does not aim to address all of these issues. Rather, the discussion will focus on two: (1) the now-optional expansion of Medicaid, and (2) the creation of state-based American Health Benefit Exchanges (AHBEs). In examining these provisions, this Note will also touch on the Act's individual mandate, along with its some of the Act's changes to Medicare and to the existing insurance market.

1. The Medicaid Expansion

The Medicaid expansion was not the PPACA's most radical provision, yet it has become controversial in the context of the U.S.'s current economic downturn. The provision modifies the decades-old public program that has provided extensive coverage to low- and middle-class children and pregnant women, but only provided limited coverage to other adults.⁶³ Historically, Medicaid required states to cover parents up to a varying income level (based on a state's welfare eligibility), and allowed states to extend their coverage

⁵⁸ Channick, *supra* note 53.

⁵⁹ Pratt, *supra* note 3, at 520.

⁶⁰ Ehley, *supra* note 21.

⁶¹ CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION, THE ACA'S MEDICAID EXPANSION: MICHIGAN IMPACT *passim* (Oct. 2012), <http://www.chrt.org/assets/price-of-care/CHRT-Issue-Brief-October-2012.pdf>.

⁶² See SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12 (detailing many facets of the new law intended to fix current problems).

⁶³ WHERE ARE STATES TODAY?, *supra* note 42, at 1.

with the aid of matching federal funds.⁶⁴ Federal minimum coverage in all states accounted only for those parents well below the federal poverty level, and states were given broad discretion as to whether that coverage should be increased.⁶⁵ Although some states did increase coverage,⁶⁶ others retained Medicaid as a lifeline for only the poorest residents.⁶⁷

The PPACA sought to establish a uniform minimum coverage requirement, i.e., one that would not vary among states.⁶⁸ The original version of the Act would have expanded Medicaid coverage to all eligible individuals: children, pregnant women, parents, *and* childless adults, with incomes up to 133% of the federal poverty level as of 2014.⁶⁹ Federal funding would have covered 100% of all newly eligible enrollees from 2014 to 2016, then would have decreased to 95% of new costs in 2017, then would have diminished gradually until locking in at 90% in 2020 and beyond.⁷⁰ This is still how the law will operate for states that choose to adopt it.⁷¹

The original version of the PPACA had a stick along with this carrot, threatening to withhold all federal assistance for Medicaid from states that did not adopt the expansion.⁷² The U.S. Supreme Court held in the abovementioned *Sebelius* decision that such a requirement constituted a coercive action intended to force states to accept the expansion.⁷³ The Court thus severed the mandatory expansion from the Act and allowed the rest of the Act to stand.⁷⁴ States now may decline the expansion without any corresponding withdrawal of funding toward their existing Medicaid programs.

⁶⁴ THE HENRY J. KAISER FAMILY FOUND., FEDERAL CORE REQUIREMENTS AND STATE OPTIONS IN MEDICAID CURRENT POLICIES AND KEY ISSUES 1 (2011), <http://www.kff.org/health-reform/fact-sheet/federal-core-requirements-and-state-options-in/>.

⁶⁵ WHERE ARE STATES TODAY?, *supra* note 42, at 5. As of July 2012, federal requirements were as low as 11% of the federal poverty level in Alabama and Louisiana. *Id.*

⁶⁶ *Id.* (listing the pre-PPACA Medicaid eligibility limits in all fifty states and the District of Columbia, including states where parents with incomes up to 200% of the federal poverty level or above were eligible, such as Maine, Minnesota, and Wisconsin).

⁶⁷ *Id.* at 2.

⁶⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271–79 (2010); SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 1.

⁶⁹ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 1.

⁷⁰ *Id.*

⁷¹ THE HENRY J. KAISER FAMILY FOUND., IMPLEMENTING THE ACA'S MEDICAID-RELATED HEALTH REFORM PROVISIONS AFTER THE SUPREME COURT'S DECISION 1 (2012), <http://www.kff.org/healthreform/upload/8348.pdf>.

⁷² Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2582 (U.S. 2012).

⁷³ *Id.* at 2604.

⁷⁴ *Id.* at 2608.

2. Health Insurance Exchanges

To address the underinsurance of the country's lower and middle classes, the PPACA provides for the establishment of government-sponsored exchanges of private insurance plans.⁷⁵ A primary aim of these exchanges is affordability, which the government hopes to achieve through both managed competition and direct subsidies.⁷⁶

First, tight regulation of insurers licensed to sell AHBEs—surely an attractive market based solely on the number of new customers⁷⁷—is intended to keep insurance companies honest.⁷⁸ The government will also provide direct subsidies (“premium credits”) to qualified individuals with incomes between 100% and 400% of the federal poverty level.⁷⁹ These credits will be based on enrollees' incomes, ensuring that poorer individuals are spending a lower percentage of their earnings on health care than those with higher incomes.

The exchanges will use government regulation not only to achieve affordability, but also quality. Insurers will only be permitted to offer “qualified health plans” (QHPs) to customers in the exchanges.⁸⁰ QHPs have cost-sharing limits⁸¹ and must provide “essential health benefits” such as ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, and preventive care.⁸² The exchanges will provide comprehensive websites where customers can compare QHPs and enroll.⁸³

The PPACA provides that if states do not establish an insurance exchange by January 1, 2014, a federal exchange will serve that states' citizens.⁸⁴ As a practical matter, the viability of a far-reaching federal exchange in the face of

⁷⁵ Pratt, *supra* note 3, at 515.

⁷⁶ Boies, *supra* note 33, at 18.

⁷⁷ See Tom Murphy, *Health Care Overhaul Seen as Boon to Insurance Industry*, ASSOCIATED PRESS, Oct. 2, 2012, available at <http://www.telegram.com/article/20121002/NEWS/110029836/1002/business#.UHt3Bf1ETYh> (estimating that an increase in private insurance enrollees will lead to \$55 billion in premiums to the insurance industry in 2014).

⁷⁸ Pratt, *supra* note 3, at 519.

⁷⁹ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 2.

⁸⁰ Pratt, *supra* note 3, at 516.

⁸¹ *Id.* Cost-sharing is the requirement that purchasers of insurance contribute some out-of-pocket payments toward their insurance plans, beyond just their premiums. The most common examples are deductibles and co-payments. *Id.*

⁸² *Id.* at 517.

⁸³ *Id.* at 516. For an example of an online insurance exchange, see that of Massachusetts, which has been in place as a purely statewide measure since 2006, the same year in which Massachusetts enacted an individual mandate. HEALTH CONNECTOR: HEALTH INSURANCE FOR MASSACHUSETTS RESIDENTS, <https://www.mahealthconnector.org/portal/site/connector> (last visited Oct. 21, 2012).

⁸⁴ Pratt, *supra* note 3, at 516.

widespread noncooperation by states⁸⁵ remains to be seen. Also unclear is what will happen to people between a state's Medicaid cutoff and 100% of the federal poverty line if a state denies the Medicaid expansion and the exchange, and the surrogate federal exchange does not extend subsidies to people below that same line. Those in limbo between the two convergent thresholds face an uncertain future, which will be explored in the analysis section of this Note.

D. An Introduction to Switzerland: Its Governmental Philosophy and Health Care System

The Swiss Confederation is a republic made up of twenty-three sovereign cantons allied under one federal government.⁸⁶ Each canton is represented in the Swiss Parliament, whose delegates are elected by popular vote, much like the U.S. legislature.⁸⁷ Far from a socialized system, the Swiss government is said to only intervene where the private sector produces unsatisfactory results,⁸⁸ a notion that seems to echo in the debate over U.S. health reform. Also similar to the U.S., powers not explicitly granted to the central government are reserved to the cantons.⁸⁹ These similarities analogize Swiss and U.S. healthcare laws insofar as they must both be achieved through the symbiosis of national and local governing bodies.

Switzerland is a wealthy nation; its income per capita currently is among the highest in the world.⁹⁰ Loyal to capitalist principles,⁹¹ the Swiss have nonetheless managed to maintain relatively equal income distribution. The World Bank ranks Switzerland ahead of the U.S. in terms of income equality.⁹²

⁸⁵ THE HENRY J. KAISER FAMILY FOUND., ESTABLISHING HEALTH INSURANCE EXCHANGES: AN OVERVIEW OF STATE EFFORTS 1 (2012), <http://www.kff.org/healthreform/upload/8213-2.pdf> [hereinafter HEALTH INSURANCE EXCHANGES: AN OVERVIEW]. As of August 2012, seven states had announced they would not create an exchange, sixteen were studying their options, and nine had taken no significant activity toward establishing an exchange or rejecting their duty. *Id.*

⁸⁶ EUROPEAN OBSERVATORY ON HEALTH CARE SYSTEMS, HEALTH CARE SYSTEMS IN TRANSITION: SWITZERLAND 1 (2009), at http://www.euro.who.int/__data/assets/pdf_file/0003/96411/E68670.pdf.

⁸⁷ *Id.* at 3.

⁸⁸ *Id.* at 9.

⁸⁹ Donahue, *supra* note 24, at 409.

⁹⁰ *Country Comparison: GDP – Per Capita (PPP)*, CENT. INTELLIGENCE AGENCY, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2004rank.html> (last visited Oct. 2, 2012) (ranking Switzerland seventeenth).

⁹¹ Donahue, *supra* note 24, at 421.

⁹² Klaus W. Deininger & Lyn Squire, *World Bank, A New Dataset Measuring Income Inequality*, 10 WORLD BANK ECON. REV. 565 (1996).

Despite being more economically homogenous, Switzerland remains an apt comparison to the U.S. because of its free-market nature. This fact has particular relevance to health care. Though approximately 98% of Swiss citizens have health insurance,⁹³ the government does not serve as their insurer, as in a socialized system like Great Britain's.⁹⁴ There are no public insurance plans, and there is ample competition among health care providers.⁹⁵ The Swiss government pays for only 24.9% of total health care expenditures in the country;⁹⁶ such spending amounts to only 2.7% of its GDP.⁹⁷

How are the Swiss able to cover so many people without a government-run insurance option? First, the government is not completely disengaged. By administering and regulating exchanges of private insurance,⁹⁸ the government plays a unique role in its citizens' individualized purchasing processes, a role that the framers of the PPACA have emulated. Further, the Swiss government requires that all citizens purchase at least Compulsory Basic Social Insurance (CBSI),⁹⁹ similar to the PPACA's individual mandate, and provides subsidies to buyers in proportion to their incomes.¹⁰⁰

These private subsidies are Switzerland's primary means of solving access issues of lower-income individuals. That is, there is no equivalent to Medicaid or Medicare in the Swiss system.¹⁰¹ All purchasers, regardless of age or income, choose from the same menu of private insurers;¹⁰² employers rarely offer insurance to their employees.¹⁰³ The subsidies ("Income Premium Reductions") include both federal and cantonal funds, with cantons having some say over the exact amount of subsidies to be distributed.¹⁰⁴ The general aim is to limit individuals' insurance expenses to around 8% of their incomes, though that percentage varies among cantons.¹⁰⁵ The wealthy are not eligible for subsidies.¹⁰⁶

⁹³ Donahue, *supra* note 24, at 423.

⁹⁴ TANNER, *supra* note 2, at 24.

⁹⁵ *Id.* at 25.

⁹⁶ *Id.*

⁹⁷ Avik Roy, *Why Switzerland Has the World's Best Health Care System*, FORBES (Apr. 29, 2011, 5:27 PM), <http://www.forbes.com/sites/aroy/2011/04/29/why-switzerland-has-the-world-s-best-health-care-system>.

⁹⁸ Kreier & Zweifel, *supra* note 24, at 92–93.

⁹⁹ *Id.* at 92.

¹⁰⁰ *Id.* at 97.

¹⁰¹ *Id.* at 110; Donahue, *supra* note 24.

¹⁰² Kreier & Zweifel, *supra* note 24, at 110.

¹⁰³ TANNER, *supra* note 2, at 25.

¹⁰⁴ EUROPEAN OBSERVATORY ON HEALTH CARE SYSTEMS, *supra* note 86, at 29.

¹⁰⁵ Kreier & Zweifel, *supra* note 24, at 97.

¹⁰⁶ Donahue, *supra* note 24, at 423–24.

The sum of these rules is a system where nearly all citizens are required to pay some portion of their insurance costs. Government involvement is further limited to basic benefits packages, which are the only kind issued through the CBSI market.¹⁰⁷ Supplemental insurance can be purchased at the discretion of the insured, but is not eligible for subsidies.¹⁰⁸

Insurers authorized to sell through Switzerland's government exchange are closely regulated.¹⁰⁹ For example, standard benefits packages have both minimum and maximum coverage requirements and thus end up sharing many similarities across various insurers.¹¹⁰ Moreover, participating insurers must price their premiums according to "community rating," a method (also adopted by the PPACA¹¹¹) where all residents of a defined geographic area are charged the same amount, irrespective of their individual health risks or medical histories.¹¹² Similarly, the Swiss system prohibits insurers from denying coverage to applicants based on pre-existing conditions, a practice known as "guaranteed issue."¹¹³ Finally, Swiss insurance providers are not allowed to make a profit on basic, compulsory plans.¹¹⁴ They can, however, profit on supplemental insurance, which has been purchased by approximately 40% of the Swiss population.¹¹⁵

Another important function of the Swiss system is cost-sharing between insurance companies and their enrollees.¹¹⁶ Switzerland's healthcare law imposes high deductibles on purchasers, with additional co-insurance payments on top of that.¹¹⁷ At a minimum, the law requires purchasers of a CBSI to pay a \$400 deductible fee and to pay 10% of costs exceeding the deductible.¹¹⁸ However, the actual copayments borne by Swiss citizens tend to be much higher, as insurers offer attractively low premiums to those who

¹⁰⁷ Kreier & Zweifel, *supra* note 24, at 92–93.

¹⁰⁸ *Id.* at 93–94.

¹⁰⁹ EUROPEAN OBSERVATORY ON HEALTH CARE SYSTEMS, *supra* note 86, at 22.

¹¹⁰ TANNER, *supra* note 2, at 25–26.

¹¹¹ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 5.

¹¹² Kreier & Zweifel, *supra* note 24, at 93; *see also* Donahue, *supra* note 24, at 424–25. In a voluntary insurance system, insurance companies are forced to adjust their ratings based on purchasers' characteristics, as charging everyone the same rate would cause comparatively healthy people not to participate. Only through a compulsory system, wherein insurance companies can rely on consistent enrollment across race, gender, and health lines, can these companies curtail this process of premium rating. *Id.*

¹¹³ Kreier & Zweifel, *supra* note 24, at 93.

¹¹⁴ *Id.* at 94.

¹¹⁵ TANNER, *supra* note 2, at 27.

¹¹⁶ Kreier & Zweifel, *supra* note 24, at 96.

¹¹⁷ *Id.* Out-of-pocket payments in Switzerland account for almost 6% of total household consumption in Switzerland, compared to about 3% in the U.S. DE LOOPER, *supra* note 32, at 146.

¹¹⁸ DE LOOPER, *supra* note 32, at 146.

accept higher deductibles.¹¹⁹ This practice, combined with the popularity of supplemental insurance, has led Swiss citizens to incur some of the highest out-of-pocket expenditures of any population in the world.¹²⁰

E. Health Outcomes in Switzerland

The results of the Swiss health care system are largely positive, at perhaps a necessary price. By many popular standards, the quality of health care in Switzerland is quite high. Wait times for medical services, a common problem in many socialized systems with global caps on health expenditures,¹²¹ are virtually nonexistent in Switzerland.¹²² According to a 2007 study by the Organization for Economic Cooperation and Development (OECD), Switzerland's life expectancy ranked second in the world, behind Japan, at just under eighty-two years.¹²³ Switzerland also performs better than the OECD average in heart disease mortality,¹²⁴ cancer mortality,¹²⁵ and adults who report being in good health.¹²⁶ Its infant mortality rate is equal to the OECD average but it is still almost half of the U.S. rate.¹²⁷

Further, as mentioned above, access rates in Switzerland benefit from the individual mandate and from government subsidies. While disparities exist as to the extent and quality of care received, typical in any market-driven system,¹²⁸ almost everyone receives basic care. Furthermore, the Swiss appear satisfied with their care: more than 71% of voters rejected a 2007 referendum to replace the current system with a single-payer approach.¹²⁹

As expected, Switzerland pays correlatively for its system's quality. The Swiss rank third in the world in health care spending relative to GDP, behind the U.S. and France,¹³⁰ and third in healthcare spending per capita, behind the U.S. and Norway.¹³¹ However, crucial to this discussion is how little of

¹¹⁹ *Id.*; TANNER, *supra* note 2, at 26.

¹²⁰ DE LOOPER, *supra* note 32, at 146.

¹²¹ *Id.* at 142.

¹²² Kreier & Zweifel, *supra* note 24, at 101.

¹²³ DE LOOPER, *supra* note 32, at 17.

¹²⁴ *Id.* at 23.

¹²⁵ *Id.* at 25.

¹²⁶ *Id.* at 37.

¹²⁷ *Id.* at 31.

¹²⁸ ROBERT E. LEU & MARTIN SCHELLHORN, INST. FOR THE STUDY OF LABOR, DISCUSSION PAPER NO. 1316, THE EVOLUTION OF INCOME-RELATED INEQUALITIES IN HEALTH CARE UTILIZATION IN SWITZERLAND OVER TIME 17 (2004), available at <http://www.econstor.eu/bitstream/10419/20582/1/dp1316.pdf> (finding that the rich in Switzerland are more likely to see a specialist than the poor, but there is no statistically significant difference in the number of general physician visits between the two classes).

¹²⁹ TANNER, *supra* note 2, at 28.

¹³⁰ DE LOOPER, *supra* note 32, at 163.

¹³¹ *Id.* at 161.

that spending comes directly from the Swiss government.¹³² The Swiss are wealthy people, operating within a system that does not limit their ability to spend freely on health care.¹³³ This explains, at least in part, how a country can amass such high health costs relative to GDP, despite lower government contributions, than any country in the developed world.¹³⁴ The U.S. could address many of its system's woes simply by meeting Switzerland's *government-spending* benchmark; the PPACA's insurance exchanges are indeed projected to shift costs away from the federal government.¹³⁵ However, if the U.S. also takes measures to mitigate out-of-pocket costs to low-income participants in its insurance exchanges, which this Note later argues it can, the U.S. can reduce overall costs to consumers in a way the spendthrift Swiss do not.

III. ANALYSIS

A. *The Current Dilemmas Facing U.S. States*

The Supreme Court's decision in *Sebelius* undoubtedly added new contours to the debate over health care access in the U.S. Now that states are permitted to reject the PPACA's Medicaid expansion¹³⁶ and may do so notwithstanding the law's mandate that everyone purchase insurance, how can states help to provide coverage to those who cannot afford it? This question is essentially twofold. First, states must decide whether to accept the Medicaid expansion. States declining the expansion face a second, more speculative question: how to care for lower and middle classes, now required to buy insurance, in the expansion's absence.

1. *The States' Initial Decision: Whether to Expand Medicaid*

As to the first determination, it is already clear that many U.S. states do not intend to follow the PPACA's course.¹³⁷ Reasons for their recalcitrance

¹³² Donahue, *supra* note 24, at 430.

¹³³ TANNER, *supra* note 2, at 28.

¹³⁴ Roy, *supra* note 97.

¹³⁵ CONG. BUDGET OFFICE, ESTIMATES FOR INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 2 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>. The Congressional Budget Office estimates that the transfer of patients toward the exchanges from Medicaid, resulting from the Supreme Court's decision to make the Medicaid expansion optional, will save the federal government \$84 billion from 2012 to 2022.

¹³⁶ Nat'l Fed'n of Indep. Bus. v. Sebelis, 132 S. Ct. 2566, 2607–08 (U.S. 2012).

¹³⁷ Ehley, *supra* note 21.

run from budget shortages¹³⁸ to political opposition¹³⁹ to ideological convictions about the role of government.¹⁴⁰ Although the federal government will initially pay for 100% of newly eligible enrollees, some states are worried about long-term costs once federal contributions subside (even though such contributions will never fall below 90%).¹⁴¹ Further, some policy analysts believe that the individual mandate created another, unsubsidized group of new Medicaid enrollees: those who were eligible for Medicaid before March 2010 but did not enroll.¹⁴² If this group seeks to satisfy the insurance mandate by enrolling in Medicaid, states will be expected to subsidize them; the federal government will only subsidize new enrollees between states' previous eligibility cutoffs and 133% of the poverty level.¹⁴³ Thus, states' calculations as to the cost of the Medicaid expansion are not solely limited to newly eligible enrollees.

Others argue that the Medicaid expansion will *reduce* costs for states, for three primary reasons: (1) many of the newly eligible enrollees will be those previously covered under state-funded programs, such as community mental health systems; (2) state-funded hospitals will benefit from providing less uncompensated emergency care, solving the so-called "free rider" problem;¹⁴⁴ and (3) states, as employers, will see a reduction in health insurance premiums because of those savings to state-funded providers.¹⁴⁵ Hospitals, particularly so-called "safety net" hospitals, which are heavily subsidized to care for a disproportionate number of uninsured or underinsured patients, are chief among those supporting the expansion as a cost-effective choice for states.¹⁴⁶ Their reasons relate to the PPACA's

¹³⁸ See *id.* (quoting Florida Governor Rick Scott, who called Medicaid the "fastest-growing part of [the] state budget," and said the expansion "doesn't bode well").

¹³⁹ Margaret Newkirk, *Mississippi Fights Over Health Law as States Resist Key Element*, BLOOMBERG (Oct. 9, 2012), <http://www.bloomberg.com/news/2012-10-09/mississippi-fights-over-health-law-as-states-resist-key-element.html> (quoting a spokesman for Mississippi Governor Phil Bryant, who said, "Governor Bryant will resist any actions that could further the implementation of Obamacare").

¹⁴⁰ See Ehley, *supra* note 21 (quoting Texas Governor Rick Perry, who called Medicaid "a system of inflexible mandates, one-size-fits-all requirements, and wasteful, bureaucratic inefficiencies").

¹⁴¹ *Id.* (quoting Florida Governor Rick Scott).

¹⁴² Fred Mogul, *Chris Christie Considers New Medicaid Math*, KAISER HEALTH NEWS (Oct. 11, 2012), <http://www.kaiserhealthnews.org/Stories/2012/October/12/new-jersey-chris-christie-medicaid.aspx>.

¹⁴³ 42 U.S.C.A. § 1396d (West 2010).

¹⁴⁴ Marshall B. Kapp, *If We Can Force People to Purchase Health Insurance, Then Let's Force Them to be Treated Too*, 38 AM. J.L. & MED. 397, 400 (2012) (internal quotation marks omitted).

¹⁴⁵ CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION, *supra* note 61.

¹⁴⁶ Carrie Teegardin, *Deal's Medicaid Decision Could Put Hospitals at Risk*, ATLANTA J.-CONST. (Aug. 30, 2012), <http://www.ajc.com/news/news/state-regional-govt-politics/deals-me>

various cuts in federal funding, such as lower reimbursements to providers treating Medicare patients and reductions in subsidies to “safety-net” hospitals,¹⁴⁷ also called disproportionate share hospitals.¹⁴⁸ Since some hospitals rely on these funds to operate,¹⁴⁹ whatever system states adopt must somehow correct for these crucial losses.

The Medicaid expansion was one such correction. First, the increased number of insured patients would presumably lead to an influx of regular, nonurgent visits, and a substantial decline in uncompensated care.¹⁵⁰ Further, the PPACA countered its reduction in Medicare reimbursements with an increase in Medicaid dollars flowing to states.¹⁵¹ Thus, states choosing not to adopt the Medicaid expansion will incur the same cuts in subsidies as every other state, but the countervailing benefit from federal Medicaid funding will be significantly lower.¹⁵²

Whatever the economic merits of the Medicaid expansion, this Note does not seek to sway readers or policymakers in any particular direction. Rather, it addresses the fallout of many states’ decisions to reject the expansion.¹⁵³ In this scenario, states should be considering alternate methods of aiding their lower classes in purchasing now-mandatory health insurance.

2. *The States’ Options After Rejecting the Medicaid Expansion*

The issues posed by states declining the Medicaid Expansion seem facile compared to the complexity that has followed some states’ wholesale rejections of the PPACA. Because the Act contains provisions that will still affect people nationwide, excluding many of these states’ citizens from the individual insurance marketplace (as would happen to people above the states’ Medicaid thresholds but below the federal exchanges’ subsidy

dicaid-decision-could-put-hospitals-at-ris/nRPQ4 (quoting hospital advocates who expected higher Medicaid reimbursements to offset decreases in Medicare reimbursements and disproportionate share payments but will not experience such an offset without more Medicaid patients).

¹⁴⁷ Elizabeth Stawicki, *Safety-Net Hospitals Brace for Cut to Federal Subsidies*, KAISER HEALTH NEWS (Oct. 14, 2012), <http://www.kaiserhealthnews.org/Stories/2012/October/15/safety-net-hospitals.aspx>.

¹⁴⁸ Lisa Potetz, Juliette Cubanski & Tricia Neuman, *Medicare Spending and Financing: A Primer*, THE HENRY J. KAISER FAMILY FOUND. 5 (2011), available at <http://www.kff.org/medicare/upload/7731-03.pdf>.

¹⁴⁹ Stawicki, *supra* note 147.

¹⁵⁰ Teegardin, *supra* note 146.

¹⁵¹ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 1–2.

¹⁵² Teegardin, *supra* note 146.

¹⁵³ See Daniel Malloy, *Deal Rejects Expansion of Medicaid*, ATLANTA J.-CONST. (Aug. 28, 2012), <http://www.ajc.com/news/news/state-regional-govt-politics/deal-rejects-expansion-of-medicaid/nRMfK> (reporting on Georgia Governor Nathan Deal’s announced rejection of the expansion).

thresholds) portends a muddle of legal and ethical problems for state and federal leaders. Most notably, low-income residents of these states will struggle to pay for insurance, defeating many of the aims of the PPACA's insurance model.¹⁵⁴ Additionally, healthcare providers will experience cuts in subsidies without a corresponding increase in insured patients.¹⁵⁵

The solution is largely built into the law these states oppose. Even when failing to extend coverage to low-income individuals through the Medicaid expansion, states can still help these individuals by embracing the health insurance exchanges established through the PPACA.

B. Why States Should Implement Insurance Exchanges to Increase Access and Lower Costs, Part One: Theory

Health insurance exchanges can increase access and lower costs through transparency, accountability, managed competition, and preventive care.¹⁵⁶ First, when an insurance company's plans and prices are made transparent to consumers on an independent, third-party website, the veil that has traditionally protected the insurance industry will be substantially lifted.¹⁵⁷ Unlike government- or employer-sponsored insurance plans, an exchange for individuals would put cost considerations in the hands of consumers, thereby incentivizing insurers to meet consumers' cost demands.¹⁵⁸ Because costs are the foremost obstacle to health care in the U.S.,¹⁵⁹ any methodology that contains costs to individual purchasers will likely have a positive effect on access.

Second, the exchanges will serve as gatekeepers of insurance practices, holding eligible insurers accountable for conduct that may advance health disparities.¹⁶⁰ The PPACA already combats longstanding insurance practices,

¹⁵⁴ The PPACA contains a "hardship exemption" for those who cannot afford insurance because their employer-sponsored coverage, or the lowest-cost plan available in their state's insurance exchange, exceeds 8% of their annual household income. 26 U.S.C. § 5000(A); Pratt, *supra* note 3, at 511. Moreover, the U.S. Department of Health and Human Services acted to exempt citizens of states declining the Medicaid expansion, who would have qualified for Medicaid under the national threshold, from paying the penalty associated with the individual mandate. 78 Fed. Reg. 39,484, 39,500 (June 26, 2013). While such relief will save eligible citizens money in the short term, they leave many without access to affordable insurance, thus perpetuating the current system: uninsured patients self-medicating until their health requires emergency care, much of which may bankrupt the patients and go uncompensated to the providers.

¹⁵⁵ Teegardin, *supra* note 146.

¹⁵⁶ Boies, *supra* note 33, at 3, 18–19.

¹⁵⁷ See Roy, *supra* note 97 (explaining how Switzerland's public definition of the minimum benefit package provides transparency to consumers purchasing private insurance).

¹⁵⁸ TANNER, *supra* note 2, at 28.

¹⁵⁹ DE LOOPER, *supra* note 32, at 143.

¹⁶⁰ J.D. Kleinke, Op-Ed., *The Conservative Case for Obamacare*, N.Y. TIMES (Sept. 29, 2012),

both inside and outside of the exchanges, through its community rating and guaranteed issue requirements, which prevent discrimination of purchasers based on socioeconomic status and medical histories respectively.¹⁶¹ The law goes a step further with respect to insurance providers within the exchanges, regulating their benefit plans,¹⁶² cost-sharing limits,¹⁶³ transparency,¹⁶⁴ accreditations,¹⁶⁵ and application processes.¹⁶⁶ The PPACA's exchanges envisage a system where insurers' freedom to shape their benefits plans is limited, to the betterment of the group most affected by such conduct: low-income individuals seeking coverage on their own.¹⁶⁷

Third, the insurance exchanges aim to generate competition among insurers, while not compromising coverage.¹⁶⁸ This can occur because insurers, enticed by the scope of the exchange's prospective market,¹⁶⁹ can only reach these new customers by embracing the necessary regulations. Further, the exchanges can increase competition by limiting the number of plans offered through the exchange.¹⁷⁰ Whether an exchange puts a hard cap on the number of plans it offers or creates qualitative limitations through extensive eligibility requirements, insurers seeking admission will face pressure to lower costs, extend access, or both.¹⁷¹ U.S. states that choose to establish their own exchanges under the PPACA can play a significant role in setting these limitations and tailoring them to the needs of their unique populations.¹⁷²

Finally, insurance exchanges have the potential to reduce long-term costs to the health care system by encouraging preventive care. If the PPACA's exchanges are successful at expanding access to health care, as antecedent

http://www.nytimes.com/2012/09/30/opinion/sunday/why-obamacare-is-a-conservatives-dream.html?pagewanted=all&_r=0.

¹⁶¹ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2613 (U.S. 2012) (Ginsburg, J., dissenting); see also Pratt, *supra* note 3, at 528 (estimating that, without reform, as many as 129 million nonelderly Americans in 2014 would be at risk of losing coverage or denied coverage altogether for having preexisting conditions).

¹⁶² Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,865 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

¹⁶³ 42 U.S.C.A. § 18071 (West 2010).

¹⁶⁴ 45 C.F.R. § 155.220 (2012).

¹⁶⁵ *Id.* § 155.1045.

¹⁶⁶ *Id.* § 155.405.

¹⁶⁷ Pratt, *supra* note 3, at 507–08.

¹⁶⁸ Boies, *supra* note 33, at 18.

¹⁶⁹ Murphy, *supra* note 77.

¹⁷⁰ Boies, *supra* note 33, at 18–19.

¹⁷¹ *Id.*

¹⁷² *Id.* at 20.

exchanges have been,¹⁷³ more people will receive basic and routine medical care, avoiding the high costs of preventable emergency care.¹⁷⁴ In addition to this natural consequence of access to insurance, the PPACA further promotes preventive care by eliminating cost-sharing—e.g., co-pays and deductibles—for certain preventive care offered under QHPs.¹⁷⁵ There is some debate as to whether preventive care in fact reduces health care costs in the aggregate.¹⁷⁶ However, the effect of preventive care on general wellness,¹⁷⁷ coupled with its benefit to healthcare providers compared to uncompensated emergency care,¹⁷⁸ makes such care a desirable element of the PPACA whether or not it produces significant savings.

Given the virtues of the PPACA's insurance exchanges, it is paradoxical that so many states are resisting their implementation. First, the Act gives the states broad latitude to customize their exchanges to their preferences.¹⁷⁹ For example, states can choose whether to open their exchanges to all eligible QHPs (the "clearinghouse" model) or selectively contract with certain QHPs that best serve their individualized needs, perhaps favoring local insurance companies (the "active purchaser" model).¹⁸⁰ The fact that this and other critical decisions are reserved to the states suggests the exchanges are not necessarily an affront to states' rights. Compared to a nationally run exchange or a public insurance option, state-run exchanges could even be said to advance those rights.

Also, the exchanges' free-market nature should appeal to many of the states that are currently resisting them. Of the sixteen states that have either formally announced their noncompliance with the PPACA's exchange requirement or have taken no action to implement an exchange, fourteen

¹⁷³ THE HENRY J. KAISER FAMILY FOUND., MASSACHUSETTS HEALTH CARE REFORM: SIX YEARS LATER 1 (May 2012), <http://www.kff.org/healthreform/upload/8311.pdf> (reporting a nearly 5% drop in uninsured Massachusetts residents four years after that state implemented a private insurance exchange; the national average during that span was a 1.3% increase).

¹⁷⁴ Boies, *supra* note 33, at 3.

¹⁷⁵ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 10–11.

¹⁷⁶ Some data suggests that disease prevention, through such preventive measures as immunizations, screenings, and tobacco cessation advice, would save the U.S. \$3.7 billion in personal health care spending annually. Contrary literature says preventive care leads to unnecessary procedures and prescriptions, adding avoidable expenditures to the system at large. Ryan Abbott, *Treating the Health Care Crisis: Complementary and Alternative Medicine for PPACA*, 14 DEPAUL J. HEALTH CARE L. 35, 45–46 (2011).

¹⁷⁷ *Id.* at 44.

¹⁷⁸ Channick, *supra* note 53, at 311–12.

¹⁷⁹ Boies, *supra* note 33, at 3.

¹⁸⁰ HEALTH INSURANCE EXCHANGES: AN OVERVIEW, *supra* note 85, at 3. States also have the option to establish a state-federal partnership exchange, wherein states can reserve certain management and customer service functions and delegate the remainder to the federal government. *Id.* at 2.

have Republican governors.¹⁸¹ Yet the exchanges discourage free-riders, keep money in the private sector, and preserve personal choice—all concepts traditionally associated with conservative political ideology.¹⁸² Indeed, the idea of partially government-subsidized purchases of private insurance within an individual mandate system was advocated in 1989 by the conservative think tank,¹⁸³ the Heritage Foundation;¹⁸⁴ adopted by Republican governor and 2012 Republican presidential nominee Mitt Romney in Massachusetts;¹⁸⁵ and recently given more Republican support.¹⁸⁶

States choosing to decline the Medicaid expansion should, for the foregoing reasons, find a happy medium in the insurance exchanges. The Department of Health and Human Services has clarified that states failing to establish their own exchanges by the January 2014 deadline are not precluded from doing so at any time in the future, provided that the exchanges comply with the federal requirements.¹⁸⁷ Thus, even those states now delegating establishment of exchanges to the federal government, or choosing a state-federal partnership exchange, can still embrace the concept of state-run exchanges, and will still receive federal funding to implement them.¹⁸⁸

Further, in establishing their exchanges, it is essential that states work with the federal government to extend the same subsidies to those below 100% of the poverty level as provided to those between 100% and 133% of the poverty level in the PPACA's current form.¹⁸⁹ As mentioned above, many states' Medicaid programs have maximum income restrictions well

¹⁸¹ *Id.* at 1. New Hampshire and Missouri are the only Democrat-led states that have rejected the exchanges or abstained from any action related to their implementation. *Id.*

¹⁸² Kleinke, *supra* note 160.

¹⁸³ See THE HERITAGE FOUNDATION, <http://www.heritage.org/about> (last visited Oct. 21, 2012) (describing the Heritage Foundation's mission as "promot[ing] conservative public policies based on the principles of free enterprise, limited government, [and] individual freedom . . .").

¹⁸⁴ THE HERITAGE FOUNDATION, A NATIONAL HEALTH SYSTEM FOR AMERICA 51 (Stuart M. Butler & Edmund F. Haislmaier eds., 1989), available at http://thf_media.s3.amazonaws.com/1989/pdf/ci_0891950494.pdf.

¹⁸⁵ Kleinke, *supra* note 160.

¹⁸⁶ See Elizabeth Stawicki, *Pawlenty Does an About-Face on Insurance Exchange Idea*, MINN. PUB. RADIO (Oct. 8, 2010), <http://minnesota.publicradio.org/display/web/2010/10/08/pawlenty-health-exchanges/> (reporting that Minnesota Governor Tim Pawlenty had sought in 2007 to establish an exchange similar to those called for under the PPACA, but was nonetheless opposing the PPACA's exchanges).

¹⁸⁷ Election to Operate an Exchange After 2014, 45 C.F.R. § 155.106 (2012).

¹⁸⁸ HEALTH INSURANCE EXCHANGES: AN OVERVIEW, *supra* note 85, at 5.

¹⁸⁹ See 26 U.S.C.A. § 36B(a), -(b)(3)(A)(i), -(c)(1)(A) (West 2012). The PPACA offers subsidies to "applicable taxpayer[s]" "[u]p to 133 percent" of the poverty level, but later defines "applicable taxpayer[s]" as those whose incomes equal or exceed 100% but do not exceed 400%.

below the federal poverty level.¹⁹⁰ Therefore, insurance exchanges in those states must, in lieu of the Medicaid expansion, provide alternative assistance to people with incomes below 100% of the poverty level, where the PPACA currently cuts off subsidies (having intended that states' expanded Medicaid programs would cover those below the line).¹⁹¹

Some have suggested these citizens can still receive subsidies by exaggerating their projected income to at least the federal poverty level, thus qualifying for subsidies through federal exchanges.¹⁹² Besides the difficulty of communicating this subterfuge to the masses, it seems perverse that the government would not simply correct a law that was causing such government-condoned illegality (i.e., lying on an application for government assistance).

Moreover, because such subsidies would be in the form of federal income tax credits,¹⁹³ this extension should not significantly affect states' cost considerations regarding the PPACA. Rather, this change should be viewed as essential to preventing the very sort of coverage gaps that existed in the pre-PPACA health care system.

C. Why States Should Implement Insurance Exchanges to Increase Access and Lower Costs, Part Two: Lessons from Switzerland

When the Swiss government enacted its most recent round of health care reforms in 1996, it emphasized solidarity among its citizenry.¹⁹⁴ Swiss authorities believed the only way to remedy inequitable health insurance practices was through compulsory insurance, which would lend practical value to features such as community rating and guaranteed issue.¹⁹⁵ With these regulations in place, Switzerland has extended coverage to virtually all of its citizens—a rare feat considering it was achieved through pro-market means.¹⁹⁶ Consumers seeking to purchase insurance can easily compare

¹⁹⁰ WHERE ARE STATES TODAY?, *supra* note 42.

¹⁹¹ 26 U.S.C.A. § 36B(b)(3)(A)(i) (West 2012).

¹⁹² Galewitz, *supra* note 22.

¹⁹³ 26 U.S.C.A. § 36B(a).

¹⁹⁴ Kreier & Zweifel, *supra* note 24, at 97.

¹⁹⁵ See Donahue, *supra* note 24, at 424–25. In a voluntary insurance system, insurance companies are forced to adjust their ratings based on purchasers' characteristics, as charging everyone the same rate would cause comparatively healthy people not to participate. Only through a compulsory system, wherein insurance companies can rely on consistent enrollment across race, gender, and health lines, can these companies curtail this process of premium rating. *Id.*

¹⁹⁶ TANNER, *supra* note 2, at 25.

premiums online, perhaps contributing to the Swiss public's high level of compliance with the country's individual mandate.¹⁹⁷

Along with, and perhaps due to, its near-universal insurance coverage, Switzerland's delivery of health care itself is fairly equitable. A recent study found no statistically significant income-based differences in the distribution of health care in Switzerland, as measured by average general physician visits.¹⁹⁸ This compares favorably with the pro-rich distribution in the U.S.,¹⁹⁹ and even ranks ahead²⁰⁰ of the heavily government-funded Canadian health care system.²⁰¹ Further, as mentioned above, Switzerland avoids the unwieldy access hurdle of waiting times for procedures that exists in many other universal health care systems.²⁰²

Thus, while Switzerland's system of partially subsidized private insurance has achieved some of its egalitarian aims,²⁰³ the question of cost remains. It is less clear whether Switzerland's insurance exchanges have significantly reduced health care costs in the aggregate.²⁰⁴ One can intuit that approaches, such as income-based subsidies, community rating, and guaranteed issue, have made health care more affordable for some who would otherwise struggle with costs.²⁰⁵ Yet, as previously discussed, aggregate health care costs in Switzerland remain among the highest in the world.²⁰⁶

This Note offers three reasons why high costs should not sound the death knell for the Swiss methodology as applied to the U.S. First, the low proportion of government expenditures comprising Switzerland's overall health care costs is a virtue worth repeating,²⁰⁷ especially in this Note's particular context. As discussed, much of the opposition to the PPACA relates to the normative role of government, and objections to the Medicaid expansion have manifested a swelling tide in opposition of higher government spending toward health care.²⁰⁸ While administration of

¹⁹⁷ For an example of a popular website used to compare Swiss insurance plans, see COMPARIS, <http://en.comparis.ch/comparis.aspx> (last visited Nov. 11, 2012).

¹⁹⁸ LEU & SCHELLHORN, *supra* note 128, at 13.

¹⁹⁹ *Id.* at 17.

²⁰⁰ DE LOOPER, *supra* note 32, at 151 tbl.6.5.1.

²⁰¹ TANNER, *supra* note 2, at 25–26. Canada's government pays for roughly 70% of the nation's health care costs, compared to the 25% paid by the Swiss government. *Id.*

²⁰² *Id.* at 24, 27, 32.

²⁰³ Kreier & Zweifel, *supra* note 24, at 100.

²⁰⁴ *Id.*

²⁰⁵ *Id.* at 93.

²⁰⁶ *Id.* at 100.

²⁰⁷ TANNER, *supra* note 2, at 26.

²⁰⁸ Ehley, *supra* note 21.

exchanges will inevitably yield certain costs to the states,²⁰⁹ Switzerland has shown that such a system relies less on the government than other alternatives. The second mitigating factor to Switzerland's high costs is the low rate at which those costs have been rising. From 1997 to 2007, Switzerland's health care costs only grew at an annual rate of 2.3%, the second-slowest rate among OECD countries during that span.²¹⁰ Third, this Note posits that anyone considering health care reform in the U.S. must acknowledge the impossibility of a single panacea rectifying the current system's myriad cost and access issues. While the Swiss model has produced high health care costs, those costs are still substantially lower than those of the U.S. and rising at a slower rate.²¹¹ Any system that stabilizes or lowers the growth rate of health care costs, while extending access to many whom the pre-PPACA system failed to account for, can hardly be characterized as a poor model for the U.S.

D. Possible Problems with the Insurance Exchanges and How They Can be Avoided

As stated in the previous section, this Note does not suggest that the PPACA's insurance exchanges will serve as a cure-all, but rather endorses them as a palatable solution to existing access and cost problems, particularly as an alternative to the Medicaid expansion. Indeed, the study of Switzerland's experience with such exchanges reveals problems that may arise in administering the U.S. exchanges. Perhaps the two most glaring problems that may surface in the U.S. are high out-of-pocket expenses and noncompliance by the purchasing public.

Switzerland's high out-of-pocket expenses²¹² may reasonably give pause to anyone considering partially subsidized insurance exchanges as a blessing to low-income populations. However, high out-of-pocket costs are not necessarily at odds with a health care system that serves lower and middle classes. The PPACA accounts for this issue, in part, by eliminating cost-

²⁰⁹ Though administrative costs are still speculative and will vary from state to state, most states intend to cover much of the exchanges' costs through 2% to 4% surcharges on insurance premiums. Julie Appleby, *Governors Weigh Options on Health Insurance Exchanges*, KAISER HEALTH NEWS (Dec. 6, 2012), <http://www.kaiserhealthnews.org/Stories/2012/December/07/governors-health-insurance-exchanges.aspx>.

²¹⁰ DE LOOPER, *supra* note 32, at 161, tbl.7.1.2. The OECD average for annual per capita growth in health expenditures between 1997 and 2007 was 4.1%. The U.S. experienced annual growth of 3.4% during that time.

²¹¹ Kreier & Zweifel, *supra* note 24, at 100. In 2007, Switzerland's per capita health care spending was \$4,417, compared to \$7,290 in the U.S.

²¹² DE LOOPER, *supra* note 32, at 147, tbl.6.3.1. At 5.9% of each household's total consumption, Switzerland's average out-of-pocket expenses tied for first (with Greece) as the highest among OECD countries. *Id.*

sharing for certain preventive services.²¹³ That is, those participating in Medicare or Medicaid, or purchasing QHPs via an insurance exchange, will be able to obtain essential preventive care without any out-of-pocket payments. The PPACA also puts general caps on cost-sharing for enrollees in an insurance exchange, putting more substantial limitations on out-of-pocket expenses of those closer to the poverty level.²¹⁴ Whether these provisions will sufficiently mitigate the issue of out-of-pocket burdens on U.S. consumers remains to be seen, but the law certainly does not leave the problem unaddressed. A campaign to encourage preventive care that is free of cost-sharing, may help to spare patients high out-of-pocket expenses attached to emergency care, as well as contribute to overall wellness.

Another possible threat to the success of the PPACA's insurance exchanges is excessive noncompliance with the law's individual mandate. Some speculate that the cost of the mandate's penalty relative to a basic insurance plan,²¹⁵ or the U.S.'s history of disobedience to legal mandates,²¹⁶ will lead to widespread nonparticipation in the purchasing market and a return to the status quo. Proponents of the second theory have pointed to the Switzerland's near-universal compliance with its automobile insurance mandate, compared to only 83% of U.S. drivers who comply with a similar mandate.²¹⁷ Yet the decision to purchase health insurance should be distinguished from the decision to purchase car insurance insofar as individuals are not certain to be in a car accident during their lifetimes, whereas conventional wisdom dictates that everyone will at some point encounter health care needs. Thus, the health insurance mandate might exert a greater gravitational force on consumers than that exerted by car insurance mandates. However, even if we assume Americans will be motivated to participate, we still must consider the cost dilemma: does the penalty for abstinence lack the teeth required to induce participation in the insurance exchanges?

²¹³ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 12, at 11. Services rated "A" or "B" by the U.S. Preventive Services Task Force will be available at minimum coverage without cost-sharing to those purchasing a qualified health plan. *Id.*

²¹⁴ *Id.* Total cost-sharing payments, including deductibles and co-insurance, cannot exceed \$1,983 (at projected 2014 rates) for individuals between 100% and 200% of the poverty level. The cap is raised to \$2,975 for those between 200% and 300%, and \$3,987 for those between 300% and 400%. In Switzerland, as of 2010, maximum cost-sharing for an individual was roughly \$3,200. *Id.*

²¹⁵ See Grace-Marie Turner, Op-Ed., *How Much is the Obamacare Mandate Going to Cost You?*, FORBES (July 24, 2012), <http://www.forbes.com/sites/gracemarieturner/2012/07/24/how-much-is-the-obamacare-mandate-going-to-cost-you> (challenging popular perception that the penalty will be cheaper than purchasing insurance).

²¹⁶ TANNER, *supra* note 2, at 25.

²¹⁷ *Id.*

The penalty for noncompliance is not negligible and may, in fact, exceed the cost of a basic health plan.²¹⁸ For example, a purchaser under 133% of the poverty level will not be required to pay more than 2% of his income on insurance through the exchanges, but would pay at least a penalty of 2.5% of his income, and likely a greater flat rate, for noncompliance.²¹⁹ Conversely, it is possible that those with lower government subsidies would be required to pay more for an insurance plan than the corresponding penalty *alone*.²²⁰ To correct for this disincentive, it is crucial that the government educate the public as to the *additional* costs associated with the failure to purchase health insurance. Health insurance, while perhaps costly in the short term, can be a source of significant savings if health needs develop for the consumer. An educational campaign by federal or state government can help remedy the issue of nonparticipation based on perceived cost savings.

IV. CONCLUSION

The U.S. health care system preceding the PPACA was a mire of porous coverage and exorbitant costs. Many among the lower and middle classes did not have sufficient access to health insurance, and thus to adequate health care. In seeking care, these populations suffered directly from exponentially increasing costs of services, products, and insurance premiums. The resulting number of uninsured patients in the U.S. led to a cost spiral in which those unable to pay for care received uncompensated emergency care, shifting costs to society at large.

The PPACA sought to remedy this and other U.S. health care ailments by extending coverage to everyone, using the combination of an individual mandate, partly subsidized insurance exchanges, and an expansion of Medicaid. However, when the Supreme Court ruled that states could not be forced to comply with the Medicaid expansion, the concern resurfaced that certain lower- and middle-class groups would fall through the cracks of the insurance system.

States that have declined to expand their Medicaid programs must somehow account for those populations if they want any improvement from the status quo. These states should look to Switzerland, which has no

²¹⁸ See 26 U.S.C. § 5000A(c) (2012). The penalty for not obtaining insurance is the lesser of (1) the average premium of “bronze” level qualified health plans, the minimum coverage provided in the insurance exchanges, and (2) a yearly amount, equaling the greater of, as of 2016, \$695 or 2.5% of the purchaser’s income. *Id.*

²¹⁹ *Id.*

²²⁰ See *id.* For example, a purchaser between 300% and 400% of the poverty level may be asked to contribute 9.5% of his income to an insurance plan, which would exceed both \$695 and 2.5% of his income. *Id.*

welfare system such as Medicaid, but still manages to insure nearly 100% of its population.

Switzerland uses government-run exchanges of private health insurance to provide basic coverage to all of its citizens, and subsidizes certain plans based on purchasers' incomes. This system has led to high-quality health care, distributed more equitably than that of the U.S.

The PPACA calls for almost identical insurance exchanges, and states would be prudent to embrace them. The exchanges, customizable by each state if the state chooses, are a pro-market rebuttal to Medicaid's egalitarianism, but can be quite egalitarian in their own right. Through competition among eligible insurers, transparency of pricing, regulation of rating practices, and income-based subsidies, the PPACA's insurance exchanges promise to extend access where it is most needed. U.S. states that choose to decline the Medicaid expansion should use these exchanges to fill their coverage gaps, as solidarity should not be a goal exclusive to Switzerland.